

No. 1-1/67-HRC

From

The Chairman,  
Hospital Review Committee,

To

The Union Minister for Health,  
Family Planning & Urban Development,  
Government of India,  
New Delhi.

New Delhi, dated the 25th April, 1968.

Sir,

On behalf of the Committee appointed by the Ministry of Health, Family Planning and Urban Development in their letter No. F.10-41/67-H, dated 16th November, 1967, to review the working of the Central Government Hospitals in Delhi and make recommendations, I have great pleasure in submitting the Report.

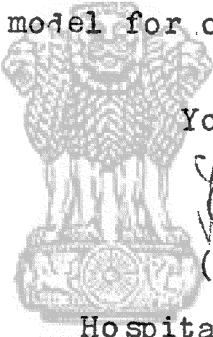
The Committee visited all institutions in Delhi, had discussions with the staff at various levels in the hospitals and also had the opportunity to hear the people speak and have their suggestions. The Committee's recommendations are broadly grouped as under:-

- i) Improvement of the internal administration of hospitals;
- ii) Co-ordination of the existing hospitals and health services in Delhi; and
- iii) Planning and Development of the future of health services in Delhi.

Of the above, some have no financial implications and should be implemented immediately. The remainder which have financial implications should be examined and implemented with minimum delay.

The Committee, after noting that there was little follow-up action taken by the authorities on the recommendations of similar committees appointed in the past, feels that there must be a Standing Committee called the "Hospital Review and Implementation Committee" to follow up its recommendations and periodically review the progress achieved. The Committee is confident that if its recommendations are implemented, the health services of Delhi will become a model for others to emulate.

Yours faithfully,



( K.N. RAO )  
Chairman,

Hospital Review Committee

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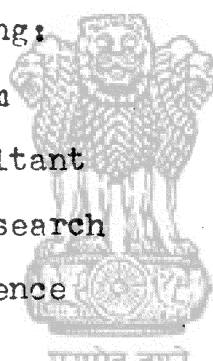
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## CHAPTER - I

### Committee's appointment, terms of reference, Procedure etc.

#### Appointment and terms of reference

(i) The Government of India in the Ministry of Health, Family Planning and Urban Development constituted an Enquiry Committee on the 16th of November, 1967, with the following terms of reference:-

- (a) to review the working of the Central Government hospitals in New Delhi with a view to improving the existing facilities for medical, surgical and specialist care;
- (b) to survey the present facilities available at the Central Government hospitals in New Delhi; and
- (c) to make recommendations for their improvement.

The Committee shall submit its report within six weeks. (The period of submission of the report was subsequently extended by the Government).

#### Composition:

(ii) The Committee consisted of the following members:-

Dr. K.N. Rao,  
Director General of  
Health Services.

CHAIRMAN

Prof. D.S. Kothari,  
Chairman,  
University Grants Commission.

MEMBER

Major-General K.K. Menon,  
Deputy Director General,  
Armed Forces Medical Services. MEMBER

Prof. B.K. Alkat,  
Director-Prof. of Pathology,  
Post-graduate Institute of  
Medical Education and Research,  
Chandigarh. MEMBER

Dr. A. Venugopal,  
Hony. Surgeon,  
Government General Hospital,  
Madras. MEMBER

Dr. P. Diesh,  
Deputy Director General (CGHS),  
Directorate General of  
Health Services. MEMBER  
SECRETARY.

On the 25th November, 1967, the Government  
expanded the Committee by appointing two additional  
members, viz.,

Dr. D.S. Raju,  
Member Parliament, &

Dr. Shantilal J. Mehta, FRCS.,  
Surgeon, Bombay.

On the 23rd November, 1967, Dr. D.S. Kothari,  
communicated his inability to serve on the Committee  
because of other commitments. Dr. D.S. Raju also  
expressed his inability to join the Committee.  
Dr. M.M.S. Siddhu, M.P., was appointed a member of  
the Committee in place of Dr. D.S. Raju on the 5th  
December, 1967.

Procedure:

(iii) The Committee held its first meeting on the  
4th December, 1967, at 2.30 P.M. in the Chamber of

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the Chairman, Dr. K.N. Rao.

The following members were present:

Dr. K.N. Rao

Major-General K.K. Menon

Prof. B.K. Aikat

Dr. A. Venugopal

Dr. P. Diesh.

Dr. Shantilal J. Mehta could not be present on the first day due to unavoidable circumstances.

(iv) The Chairman in welcoming the members gave a brief resume of the medical care arrangements in Delhi. The Government of India is directly administering the Willingdon and Safdarjang Hospitals while the All India Institute of Medical Sciences and the Lady Hardinge Medical College and Hospital, although autonomous, are however, functioning under the aegis of the Ministry of Health, Family Planning and Urban Development. The Irwin and the G.B. Pant Hospitals are under the administrative control of the Delhi Administration. The Municipal Corporation of Delhi controls the Hindu Rao, Infectious Diseases and Silver Jubilee Tuberculosis Hospitals. The tuberculosis Association of India is administering the Tuberculosis Hospital at Mehrauli. The medical care in the Union Territory of Delhi is

accordingly being handled by multiple agencies. Although the terms of reference restricted the survey to the Central Government hospitals, it was fairly clear that in any scheme of rationalisation of hospital services for Delhi a study of Central Government hospitals alone would not give a complete picture of the problem. The autonomous teaching institutions under the Ministry of Health, Delhi Administration and Delhi Municipal Corporation authorities were therefore requested to extend their co-operation to the Committee.

(v) Giving the historical background of the development of health services in Delhi the Chairman pointed out how the fulfilment of public expectations had been delayed for various reasons. The development of hospital and health services since 1947 had not kept pace with the increase in population.

The Delhi Administration had appointed a Committee in 1953 under the Chairmanship of Dr. M.D.D. Gilder to report on the medical and health situation in Delhi State. This Committee (1955) had made certain recommendations to the then State Government of Delhi and had expressed the view that adequate coordination between hospitals and dispensaries did not exist in matters of X-ray and laboratory investigations

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as well as specialists advice and guidance. The Committee had recommended that there should be close relationship between large hospitals and smaller institutions located in one area irrespective of the fact whether such hospitals or institutions were maintained by Government/Local Bodies/Missionaries/Charitable Organisations.

(vi) The Estimate Committee in its report (1958-59) also expressed the same views and pointed out that in view of the high cost of specialised equipment, the increase in the number of patients and existing shortage of specialists, it was becoming more and more imperative to make the best possible use of the available specialised facilities in different hospitals in Delhi and New Delhi to the maximum advantage of the patients requiring such facilities. This Committee suggested that a system of pooling such specialised facilities under a Central coordinating organisation for guiding the patients to the appropriate specialists in different hospitals on a regional basis should be worked out.

(vii) Subsequently, the Health Survey and Planning Committee submitted its report in October, 1961, emphasising the need for coordinated preventive and curative services.

In the past fifteen years two other major developments had taken place. The industrial workers and their families had been brought under

the Employees' State Insurance Scheme and the Central Government servants and their families under the purview of the Central Government Health Scheme.

In 1963, the Government of India appointed another Committee under the Chairmanship of Dr. K.N. Rao to study the then existing health services in Delhi and make recommendations. The Committee, among other recommendations, suggested re-organisation and zonal distribution of health services for Delhi. Unfortunately the recommendations of these Committees had not been implemented.

(viii) Continuing, the Chairman stated that certain basic data had been obtained from hospitals on the basis of a questionnaire (Appendix II Vol. 2). The Committee would visit hospitals, interview staff and obtain opinions of expert panels. Oral and written evidence would be invited through the medium of the Press.

(ix) The hospital staff, practically of all categories had threatened to go on strike during the last few years. As no hospital could function as an efficient unit unless there was coordination between the different disciplines and the staff was contented, it was necessary to go into this question. Further, the need for regionalisation and decentralisation of medical facilities had not been properly appreciated.

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(x) The Committee decided to complete visits of the institutions during the week, i.e. 4th to 9th December, 1967. It also decided to record oral evidence and to study written evidence received.

(xi) The first round of visits to hospitals from 4th to 7th December was primarily concerned with examination of service to patients. As almost all the institutions are recognised for undergraduate and post-graduate medical training, a Sub-Committee consisting of Dr. S.J. Mehta and Dr. A. Venugopal visited the institutions on the 8th and the 9th December, 1967, for the specific purpose of examining existing facilities for medical education and research.

(xii) Another sub-committee comprising of Major-General, K.K. Menon, Dr. M.M.S. Siddhu and Dr. P. Dresh visited the Infectious Diseases Hospital, Tuberculosis Hospitals, New Delhi Tuberculosis Clinic, Mental Hospital and a Private Nursing Home on 22nd December, 1967. Details of the visits of the main Committee and sub-committees may be seen in Appendix II (Vol. 2)

(xiii) The Committee through press note and advertisement in daily papers invited suggestions for the improvement of the working of the hospitals. Senior medical administrators in the different Ministries, hospitals and institutions were invited for discussion. The Committee also met the representatives of para-medical and ancillary staff working in hospitals. The Committee recorded oral evidence on 8th, 13th, 24th and 25th December, 1967 and 3rd January, 1968. The list of persons interviewed and the individuals and organisations who submitted memoranda is at appendix IVI Vol. 2.

(xiv) The Committee also constituted expert panels in different specialities to prepare reports for the following:-

Surgical service.

Medical Service.

Obstetrics & Gynaecology Service.

Anaesthesiology & Theatre discipline

Paediatrics

Laboratory services and infection

Education & Training

Blood Transfusion

Pharmacy

Medical Stores, accounting procedure,  
Hospital Administration & Regional  
Boards.

Nursing

Health Education in hospitals.

Medico-legal aspects of medical care.

Kitchen and diet in hospitals.

List of the members of expert panels is at Appendix V, Vol. 2.

(xv) During February and March, 1968, the Chairman visited the United Kingdom for two weeks to study the working of the National Health Services and the Regional Hospital Board set up and later visited the Continent to see the working of the Health Insurance Schemes. He also took the opportunity to discuss with the Regional Director, World Health Organisation, South East Asia Region, regarding W.H.O. assistance for consultant services for Delhi hospitals.

(xvi) The Committee had visited All-India Institute of Medical Sciences Hospital along with the other hospitals in December, 1967. Subsequently, the Ministry of Health, Family Planning and Urban Development informed the Committee that the terms of reference did not require an examination of this Institute and that the Committee could, however, keep the facilities available at the Institute in view, while framing their recommendations on the working of the Central Government hospitals. The Committee on the other hand felt that it was not possible to make any recommendations for the future set up of hospital and health services in Delhi without taking into consideration

the present development of the All-India Institute of Medical Sciences and its role in the co-ordinated development of these services in Delhi. It was later clarified by the Ministry that the Committee was at liberty to present the factual position with regard to the existing facilities at this Institute. The Union Minister for Health, during the course of discussion with the Committee members on 30th March, 1968, reiterated that the Committee should look into the working of all Institutions including the All-India Institute of Medical Sciences.

Acknowledgements:

(xvii) In framing its recommendations for hospital and health services in Delhi, the Committee has taken into consideration the observations and recommendations made in the Delhi State Medical and Health Reorganisation Enquiry Committee Report (1955), Health Survey and Planning Committee Report (1961), Committee on Reorganisation and Zonal Distribution of Health Services, Delhi (1963) and the report of the Study Group on Hospitals (1968).

The Committee has also taken advantage of various reports on recent trends on health services and allied matters of different countries. Of these, special reference is made to the Report of the Royal Commission on Health Services, Canada;

Reports of the Ministry of Health, United Kingdom and Scottish Home and Health Department; Department of Health, United States of America; Health Services in U.S.S.R.; Seminar on Hospital Administration in India, 1961 and the Lancet of 15th July, 1967 for "Coronary Care Unit".

The Committee received memoranda from individuals and organisations which provided a great deal of information on different aspects of hospital and health services. Many also appeared in person before the Committee. To all these individuals and groups, the Committee would like to express its appreciation.

In the course of its deliberations, the Committee visited different hospitals which enabled it to observe health care programmes in the institutions, their organisation, administration etc. The Committee is grateful to the Directors/Principals/Superintendents and other staff of the hospitals for their valuable cooperation.

The Committee would like to place on record its thanks to the officers of the Ministry of Health and the Directorate General of Health Services for their valuable assistance.

The Committee is indebted to the expert panels for their reports.

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The Committee would also like to express its thanks to the Regional Director, W.H.O., South East Asia Region. In particular, thanks are due to Dr. Bridgman, Chief of Medical Care, W.H.O. Headquarter, Geneva for his valuable contribution.

The Committee is indebted to the authorities of the Delhi Administration, the Delhi Municipal Corporation and the Tuberculosis Association of India for their cooperation in enabling it to study the working of the institutions under their jurisdiction.

The Committee wishes to record its appreciation and convey its most sincere thanks to Dr. R.S. Chawla of the Directorate General of Health Services for his invaluable assistance in preparing this report.

The Committee also express its thanks to the ministerial staff of the Directorate General of Health Services for their assistance.



## CHAPTER - 2

### SUMMARY OF MAIN CONCLUSIONS AND RECOMMENDATIONS

(1) Although the original terms of reference related only to Central Government hospitals in New Delhi, the Committee felt that a study of these hospitals alone would not give a complete picture of the problem. In any scheme of rationalisation of hospital services for Delhi, - the Central Government hospitals could not be considered in isolation from other hospitals in Delhi. The Committee is glad to record that the Government agreed to its examination of all the major hospitals of Delhi.

(2) A multiplicity of agencies viz. Central Government, Delhi Administration, Delhi Municipal Corporation, New Delhi Municipal Committee, Autonomous Boards of the two teaching institutions, Tuberculosis Association of India, Employees State Insurance Corporation, etc. control the hospitals and specialist services in Delhi. There is a complete absence of any collaboration, co-ordination and planning among these agencies.

(3) Development of hospital services has therefore been haphazard without due regard to economy or the needs of the population on a Regional basis. Institutions have been allowed to develop in close proximity of each other in certain areas, resulting in multiplication and duplication of certain services. On the other hand in other areas,

no hospital service is available at a reasonable convenient distance.

(4) Certain institutions have been permitted unrestricted expansion both vertically and horizontally - without any consideration of their capacity to handle the workload. This has lowered the efficiency of patient care.

(5) The scale of accommodation, nature of specialities, quality and scale of equipment and staffing pattern vary from hospital to hospital in Delhi. Standardization hardly exists.

(6) The Committee is much impressed by the formidable amount of work handled daily at the out-patient, inpatient and diagnostic departments of these hospitals in spite of many handicaps.

(7) The Committee would like to draw attention to the working conditions under which hospital staff has to function. Patients occupying floors and verandahas is a normal feature of most hospitals. The staff strength - medical, nursing and para-medical - has not been augmented to meet this extra responsibility. The budget provision has also not been proportionately increased. Such abnormal conditions which prevail all the time place a heavy strain on the limited staff, and ... affect the efficiency of patient care adversely. There has not been sufficient appreciation of the performance of hospital staff in the face of such heavy odds.

(8) In focussing attention on the deficiencies and shortcomings referred to below, the guiding consideration before the Committee has been to suggest ways and means to make the best use of hospital services - the most costly element of the community health care - and to improve the quality of patient care,

(9) Broadly the problems are:

(a) Medical care is a single entity whether it is made available at the hospital, health centre/dispensary or at the home. Such a comprehensive scheme of health care does not exist in Delhi for the community as a whole nor do the hospitals in Delhi occupy a central place in such a scheme, as they should;

(b) Internal administration is weak. There is no collective thinking - general management and clinical policy which are clearly inter-related, are divorced from each other. Hospital medical superintendent as a rule does not associate the clinical staff in the day-to-day management;

(c) The Medical Superintendent, loaded with clinical and teaching responsibilities, has not been able to devote personal attention to the administrative matters. He has to rely mainly on a few junior and often inexperienced team of administrative staff;

(d) None of the hospitals has any

standing orders and manuals for the guidance of hospital staff;

(e) There is considerable room for improvement in the general sanitation of the hospitals. Hardly any hospital disposes of refuse by incineration. Dead tissues, soiled dressings etc. are thrown in to public receptacles;

(f) In the Lady Hardinge Hospital a large area of valuable ground is occupied by unauthorised hutments. The occupants create insanitary conditions and difficulty for administration;

(g) Congestion in out-patients is universal. All types of cases - minor, serious, acute and chronic report at the hospital out-patient in the absence of adequate out-patient service in the periphery;

(h) Over-crowding in wards in all hospitals is a normal phenomenon. All types of cases even those requiring investigations only, are treated side by side in the same ward. Clean linen is in short supply. Sanitary facilities are not adequate. Hospitals have no provision for sterilisation of mattresses or disinfection of blankets. None of the hospitals have adopted the system of "progressive patient care";

(i) The number of operation theatres is grossly inadequate in all hospitals. Consequently the same theatre is shared by more than one

discipline. Most hospitals do not have separate septic theatre. Modern equipment for anaesthesia, central sterile supply service, and central supply for medical gases and central suction, which are essential pre-requisites in the present day operation theatre, are available only in the Safdarjang Hospital and the All-India Institute of Medical Sciences. Other hospitals have only one or the other or none of these facilities.

(j) Central sterilization department has still to develop in most hospitals. Bacteriological sterility of the supplies of this department is not regularly checked to ensure proper quality:

(k) The quality of diagnostic service in general and of "clinical pathology" in particular, provided in most hospitals does not meet the present day requirements of a modern hospital. This service is deficient in the OPD, emergency department, paediatric unit as also in the main hospital laboratory;

The microbiology section of the hospital is not actively associated in the task of prevention of hospital infection or in the regular study and control of sterility in different parts of the hospital;

(l) In all hospitals, radiological department has a very heavy load to carry. The diagnostic service is deficient in some respects in some hospitals.

Radio-therapy is functioning well in Safdarjang Hospital, All India Institute of Medical Sciences and Irwin Hospital. In other institutions it is both inadequate and ineffective;

(m) There is no co-ordination between the Blood Banks of various hospitals. They depend for blood on professional donors which is a very unsatisfactory situation. Voluntary donor system has not taken root so far;

The blood bank in the Lady Hardinge Hospital does not function;

In some hospitals, infusion fluids are prepared in the blood bank which is normally the functions of the hospital pharmacy;

(n) The factors contributing to the problem of hospital infection and cross-infection e.g. overcrowding in hospitals, uncontrolled traffic, insufficient attention to principles of hygiene and asepsis in the wards/theatres and unhygienic methods of dust removal continue to exist in Delhi hospitals. Regular quality control measures have not been adopted to check the efficiency of sterilization. The problem of infection is real and requires to be looked into immediately.

(o) In spite of considerable attention having been paid to the organisation of the emergency and accident service during the past

few years, this service cannot yet claim to be functioning effectively in any of the hospitals. Supporting diagnostic facilities are not available in some hospitals. Intensive care units have to be developed. The ambulance service continues to be unsatisfactory due to insufficient number of ambulances on road;

(p) While it is essential that all hospitals should be adequately staffed and equipped to provide patient care of a reasonable standard, the uncontrolled development of special disciplines in all hospitals should not be encouraged;

(q) The maintenance of proper medical records and 'patient care evaluation' have yet to develop in Delhi hospitals. There is also no provision for carrying out autopsy of patients dying in hospitals for want of legislation;

(r) There is no standardisation of hospital diets. Cost of general ward diet ranges from Rs.1.16 to Rs.2.50 in different hospitals. The general upkeep of the catering service and enforcement of health check up of the kitchen staff have not received due attention;

(s) Public relations and patients' welfare require more attention. Of these, provision of round the clock Enquiry and Information centre with complete information regarding seriously ill and dangerously ill patients and daily admissions and deaths; provision of

dharmasala facilities for relatives of patients from out-stations; canteen arrangements; accommodation for overnight stay of attendants of seriously and dangerously ill patients near the patient; health education and preventive health facilities deserve urgent attention. The Departments of 'clinical pathology' and radiology and operation theatres in all hospitals require complete reorganisation.

(10) Deficiencies in hospital services in general and appropriate remedial measures have been ably brought out by the Health Survey and Planning Committee in 1961. Implementation of this Committee's recommendations was, however, delayed due to the economic difficulties resulting from the Chinese aggression of 1962 and - the Indo-Pakistan Conflict of 1965. In spite of this set-back, however, it is commendable that individual agencies have continued to make efforts to expand their health services within their limited resources. The absence of a Central Coordinating body for planned development, the continued pressure of growing population, the influx of population into Delhi from surrounding regions and the agitational approach of the hospital workers have all contributed to the present state of hospital services in the Capital.

The Committee is also aware that so much



and hopes that with the implementation of the recommendations given below the Health Services of Delhi will soon set an example worthy of emulation by others in the shortest possible time in the foreseeable future.

(11) The Committee would like to place on records its appreciation of the dedicated and devoted service rendered by the majority of doctors, nurses and other hospital staff in Delhi in the face of heavy odds. It is regrettable that their sincere work has been over-shadowed by the lapses of a few.

The Committee considers:

(12) THAT THE HOSPITAL SHOULD FUNCTION  
AS AN INTEGRAL PART OF THE COMPREHENSIVE HEALTH SERVICE BOTH CURATIVE  
AND PREVENTIVE.

The Committee recommends:

Administration

(13) THAT THE ADMINISTRATION OF AN  
INDIVIDUAL HOSPITAL CALLS FOR A  
GROUP RESPONSIBILITY AND COLLECTIVE

- Medical  
Superintendent
- (14) THINKING (Para.100)  
THAT THE OFFICE OF THE MEDICAL  
SUPERINTENDENT SHOULD BE A FULL-  
TIME APPOINTMENT WITH NO CLINICAL  
RESPONSIBILITIES (Para.104)
- (15) THAT THE ADMINISTRATIVE STRUCTURE  
SHOULD BE TRIPARTITE;
- a) CLINICAL,
  - b) NURSING, &
  - c) LAY OR BUSINESS ADMINISTRATION.
- (Para.103)
- (16) THAT IN EACH HOSPITAL DIFFERENT  
SPECIALITIES SHOULD CONSTITUTE  
DIVISIONS WITH THE SENIOR MOST  
PERSON AS CHAIRMAN (Para. 103)
- Executive  
Committee
- (17) THAT THE CHAIRMEN OF DIFFERENT  
DIVISIONS WITH THE MEDICAL  
SUPERINTENDENT OF THE HOSPITAL  
AS CONVENOR WILL FORM AN EXECUTIVE  
COMMITTEE (Para. 103)
- Standing  
Committee
- (18) THAT STANDING COMMITTEES SHOULD  
BE ESTABLISHED FOR PURPOSES OF  
AUDITING ACCOUNTS, STOCK VERI-  
FICATION, CONDEMNATION BOARDS  
ETC. ETC. (Para 106)

- Standing orders (19) THAT EVERY HOSPITAL SHOULD PREPARE  
A COMPLETE SET OF STANDING ORDERS  
DEFINING THE DUTIES AND POWERS OF  
MEMBERS OF HOSPITAL STAFF (Para. 105)
- Medical Store  
equipment (20) THAT TRAINED STORE KEEPERS SHOULD  
HANDLE HOSPITAL STORES AND WORK  
UNDER THE DIRECT SUPERVISION OF  
A SENIOR OFFICER (Para. 107)
- (21) THAT ADEQUATE ACCOMMODATION (COLD  
STORAGE AND SHELVES) SHOULD BE  
PROVIDED FOR DIFFERENT STORES  
(Para. 107)
- (22) THAT HOSPITALS SHOULD ADOPT THE  
NATIONAL FORMULARY. DRUGS SHOULD  
BE INDENTED FOR BY PHARMACEUTICAL  
NAMES. (Para. 107)
- (23) THAT EACH HOSPITAL SHOULD HAVE A  
DRUGS COMMITTEE. (Para. 107)
- (24) THAT AN ORGANISATION FOR QUALITY  
CONTROL OF DRUGS SUPPLIED TO  
HOSPITALS SHOULD BE ESTABLISHED  
(Para. 110)
- (25) THAT STANDARDIZATION OF EQUIPMENT  
AND STORES IS ESSENTIAL FOR HOSPITALS.  
(Para. 109)
- (26) THAT EACH LARGE HOSPITAL SHOULD  
DEVELOP PHARMACY SERVICE TO UNDERTAKE,

- UNDER PROPER ASEPTIC CONDITIONS PREPARATION  
OF INTRAVENOUS AND OTHER FLUIDS REQUIRED  
FOR THE HOSPITAL USE. (Para.110)
- Central (27) THAT A CENTRAL MACHINERY FOR ALL  
Purchase Organisation. HOSPITALS SHOULD NEGOTIATE RATE  
CONTRACTS WITH SUPPLIERS FOR HOSPITAL  
EQUIPMENT AND STORES (Para.108)
- Central (28) THAT A CENTRAL WORKSHOP FOR MAINTENANCE  
Workshop AND REPAIR OF HOSPITAL EQUIPMENT  
SHOULD BE ESTABLISHED (Para.112)
- (29) THAT THE MAINTENANCE ENGINEERING STAFF  
IN THE HOSPITAL SHOULD BE PLACED UNDER  
THE MEDICAL SUPERINTENDENT (Para.118)
- (30) THAT TO ENSURE UNINTERRUPTED SUPPLY OF  
WATER AND ELECTRICITY DUE TO BREAKDOWN  
OF THESE SERVICES, EVERY HOSPITAL  
SHOULD HAVE ARRANGEMENTS FOR ALTERNATIVE  
SOURCE OF WATER SUPPLY AND  
ELECTRICITY. (Para.113)
- Sanitation (31) THAT EACH HOSPITAL SHOULD HAVE A  
SANITARY SQUAD TO ENSURE A HIGH STANDARD  
OF GENERAL SANITATION (Para.114)
- (32) THAT DEAD TISSUES, SOILED DRESSINGS,  
AMPUTATED LIMBS ETC. SHOULD BE DISPOSED  
OFF BY INCINERATION (Para.114).

Diet &  
Kitchen

- (33) THAT UNAUTHORISED QUARTERS SHOULD NOT BE ALLOWED TO BE PUT UP IN HOSPITALS. (Para 114)
- (34) THAT DIETS FOR ALL HOSPITALS SHOULD BE STANDARDIZED. (Para.115)
- (35) THAT PROPER CHECKS ON THE QUALITY AND QUANTITY OF STORES RECEIVED SHOULD BE EXERCISED BY THE STORE OFFICER (Para 115)
- (36) THAT SEPARATE COLD STORAGE ACCOMMODATION BE PROVIDED IN THE HOSPITAL KITCHEN (Para. 115)
- (37) THAT FOOD SHOULD BE DESPATCHED TO WARDS IN PROPER THERMO STATIC TROLLEYS WITH ARRANGEMENTS FOR LOCKING (Para. 115)
- (38) THAT THE DIETICIAN SHOULD SUPERVISE THE GENERAL AND SPECIAL DIET KITCHENS (Para 115)
- (39) THAT THE SIX MONTHLY HEALTH CHECK UP OF FOOD HANDLERS AND OTHERS WORKING IN THE KITCHEN SHOULD BE STRICTLY ENFORCED AND RECORDS MAINTAINED. (Para. 115)

- (40) THAT ALL HOSPITALS SHOULD MAINTAIN  
A RESERVE STOCK OF RATIONS FOR  
EMERGENCIES (Para 115)
- Laundry (41) THAT FOR WASHING OF LINEN, HOSPITALS  
SHOULD MAKE USE OF MECHANICAL  
LAUNDRY (Para 116)
- (42) THAT MATTRESSES STERILIZER SHOULD  
BE HOUSED IN THE BUILDING WHERE  
LAUNDRY IS LOCATED (Para 116)
- Linen (43) THAT THE HOSPITAL LINEN SHOULD BE  
STANDARDIZED (Para 117)
- Transport (44) THAT HOSPITALS SHOULD ENSURE ROAD  
WORTHINESS OF AMBULANCES AND OTHER  
VEHICLES (Para 118)
- Public  
Relations (45) THAT ALL HOSPITALS SHOULD HAVE A  
CENTRAL RECEPTION AND ENQUIRY FOR  
INPATIENTS IN THE CASUALTY BLOCK  
PROVIDING ROUND THE CLOCK SERVICE.
- (46) THAT EVERY HOSPITAL SHOULD HAVE A  
BOOKLET GIVING ESSENTIAL INFORMATION  
FOR THE GUIDANCE OF PATIENTS.
- (47) THAT PROPER SIGN POSTING INCLUDING  
NIGHT SIGNS BE PROVIDED FOR  
GUIDANCE OF PATIENTS AND VISITORS.

- (48) THAT FOR THE SERIOUSLY ILL PATIENTS PERMISSION SHOULD BE GIVEN FOR RELATIONS TO STAY NEARBY.
- (49) THAT DHARAMSALA TYPE FACILITIES FOR STAY OF VISITORS FROM OUTSTATIONS BE PROVIDED NEAR HOSPITALS.
- (50) THAT CANTEEN FACILITIES FOR VISITORS ARE NECESSARY.
- (51) THAT THE GOVERNMENT SHOULD TAKE EARLY STEPS TO AMEND THE INDUSTRIAL DISPUTES ACT SO THAT ITS PROVISIONS DO NOT APPLY TO HOSPITALS, TEACHING INSTITUTIONS, DOCTORS, NURSES AND OTHER HOSPITAL WORKERS (Para 119)
- (52) THAT THE GOVERNMENT SHOULD TAKE EARLY STEPS TO CONSTITUTE MACHINERY TO RESOLVE GENUINE GRIEVANCES OF THOSE WORKING IN THE HOSPITALS (Para 119)
- (53) THAT IN THE INTEREST OF THE DOCTORS AS WELL AS ADMINISTRATION ANY LAPSES IN THE ATTENTION TO PATIENTS SHOULD BE GONE INTO IMMEDIATELY BY AN APPROPRIATE BODY (Para 119)
- (54) THAT A COMMITTEE BE SET UP TO DEVISE A SUITABLE SYSTEM OF COST ACCOUNTING OF HOSPITAL EXPENDITURE (Para 120)

Hospital  
costs.

Laboratory & Radiological services:

Laboratory  
services.

- (55) THAT THE LABORATORY SERVICES SHOULD CONSIST OF A DIVISION OF HAEMATOLOGY INCLUDING BLOOD BANK, MICROBIOLOGY INCLUDING PARASITOLOGY AND IMMUNOLOGY, BIOCHEMISTRY AND MORBID ANATOMY, EACH OF THESE DIVISIONS SHOULD BE UNDER THE CHARGE OF ONE OR MORE MEDICAL OFFICER (Para 121, 122)
- (56) THAT THE SENIOR-MOST OFFICER INCHARGE OF LABORATORIES SHOULD BE THE HEAD OF DEPARTMENT (Para 121-122)
- (57) THAT ADEQUATE NUMBER OF TECHNICAL STAFF SHOULD BE PROVIDED.
- (58) THAT EACH OF THE HOSPITALS SHOULD ORGANISE A CENTRAL COLLECTION ROOM (Para 121-122)
- (59) THAT THE EMERGENCY LABORATORY SHOULD BE SITUATED IN CLOSE PROXIMITY TO THE INTENSIVE CARE AND EMERGENCY SERVICE UNITS (Para 121-122)
- (60) THAT OUTPATIENT LABORATORY SHOULD BE LOCATED NEAR THE CENTRAL COLLECTION ROOM WITH FULL COMPLEMENT OF TECHNICAL STAFF AND WORK UNDER SUPERVISION.
- (61) THAT EACH OF THE LABORATORIES SHOULD BE PROPERLY EQUIPPED (Para 121-122)



Radio  
diagnosis

- (62) THAT THE EXISTING PHYSICAL FACILITIES SHOULD BE AUGMENTED WHERE SHORT (Para 123).
- (63) THAT MORE TRAINED RADIOLOGISTS AND TRAINED RADIOGRAPHERS BE APPOINTED.
- (64) THAT "APPOINTMENT SYSTEM" BE INTRODUCED FOR INVESTIGATIONS FOR OUTPATIENTS.
- (65) THAT ROUND THE CLOCK EMERGENCY SERVICE SHOULD BE PROVIDED.
- (66) THAT PROPER DOCUMENTATION AND STORAGE OF X-RAY PICTURES BE ORGANISED IN ALL HOSPITALS.

Radiotherapy

- (67) THAT RADIO THERAPY UNITS BE ORGANISED IN THE MAULANA AZAD, SAFDARJANG AND ALL INDIA INSTITUTE OF MEDICAL SCIENCES (Para 124).
- (68) THAT RADIO THERAPY UNIT IN THE LADY HARDINGE HOSPITAL SHOULD BE DEVELOPED.
- (69) THAT A MINIMUM OF 20 BEDS SHOULD BE AVAILABLE TO THE THERAPY UNIT.
- (70) THAT REGULAR CANCER CLINICS SHOULD BE INTRODUCED WITH PROPER "FOLLOW UP".
- (71) THAT THE RADIOLOGICAL AND LABORATORY DEPARTMENTS SHOULD BE PROVIDED WITH STENOGRAPHERS.

- Blood Bank (72) THAT A CENTRAL BLOOD BANK SHOULD BE  
STARTED IN DELHI TO FEED THE  
SUBSIDIARY BANKS IN HOSPITALS  
(Para 125, 182)
- (73) THAT THE BLOOD BANK SERVICE SHOULD  
DEPEND ON "VOLUNTARY" RATHER THAN  
"PAID" DONARS (Para 125)
- (74) THAT THE BLOOD BANKS IN HOSPITALS  
SHOULD NOT BE BURDENED WITH PREPARATION  
OF OTHER INFUSION FLUIDS (Para 125).

Medical Service:

- Out-patients (75) THAT TECHNICAL PERSONS LIKE PHARMACISTS  
SHOULD BE TAKEN OFF FROM THE REGISTRATION  
WORK IN THE O.P.D. AND OTHER NON-  
TECHNICAL DUTIES OF THE HOSPITAL  
(Para 126)
- (76) THAT AN ENQUIRY COUNTER IS ESSENTIAL IN  
THE OPD TO GUIDE PATIENTS TO THE  
DIFFERENT DEPARTMENTS (Para 126)
- (77) THAT ADEQUATE X-RAY AND LABORATORY  
FACILITIES SHOULD BE AVAILABLE IN THE  
OPD OF ALL HOSPITALS TO CONSERVE THE  
OCCUPATION OF COSTLY BEDS BY PATIENTS  
NEEDING INVESTIGATION (Para 126)
- (78) THAT A WELL ORGANISED OPD BE PROVIDED  
IN THE SAFDARJANG HOSPITAL (Para 126)

- (79) THAT THE OUTPATIENT DEPARTMENT IN THE KALAVATI SARAN HOSPITAL SHOULD BE EXPANDED TO MEET THE GROWING DEMAND (Para 126)
- (80) THAT ADDITIONAL CONSULTING ROOMS ARE REQUIRED IN THE IRWIN HOSPITAL (Para 126)
- (81) THAT THE CONSTRUCTION OF A NEW OPD BLOCK IN THE HINDU RAO HOSPITAL BE EXPEDITED.

Inpatients.

- (82) THAT A SYSTEM OF PROGRESSIVE PATIENT-CARE SHOULD BE ORGANISED IN EACH HOSPITAL (Para 127)
- (83) THAT EACH HOSPITAL SHOULD ORGANISE AN INTENSIVE CARE UNIT OF 4-6 BEDS AND A POST-OPERATION WARD OF 10-20 BEDS (Para 128)
- (84) THAT ACCOMMODATION IN GENERAL WARDS SHOULD PREFERABLY BE IN SMALLER UNITS i.e. SICK-BAYS WITH 4 TO 6 PATIENTS (Para 127)
- (85) THAT EACH UNIT OF ABOUT 50 BEDS SHOULD BE PROVIDED WITH TREATMENT ROOM, CLINICAL SIDE ROOM AND SEMINAR ROOM FOR TEACHING. (Para 127)

As for the individual hospitals, the Committee recommends:

- (86) THAT NO ADDITIONAL BEDS BE ADDED TO THE WILLINGDON, SAFDARJANG AND IRWIN HOSPITALS (Para 127)

(87) THAT INTENSIVE CARE UNITS SHOULD BE ORGANISED IN WILLINGDON, AIIMS, LADY HARDINGE, IRWIN AND SAFDARJANG HOSPITALS (Para 128)

(88) THAT IN THE HINDU RAO HOSPITAL SHORTAGE OF STAFF, DEFICIENCY IN EQUIPMENT AND THE SUPPORTING SERVICES SHOULD BE IMMEDIATELY REMEDIED (Para 128)

WILLINGDON HOSPITAL

(89) THAT NURSING HOME FACILITIES SHOULD BE AVAILABLE FOR ALL THE SPECIALISTS (Para 127)

Paediatrics

(90) THAT ALL PAEDIATRIC UNITS SHOULD HAVE A WELL EQUIPPED MICRO-TECHNIQUE LABORATORY PROVIDING ROUND THE CLOCK SERVICE WITH A QUALIFIED TRAINED TECHNICIAN UNDER SUPERVISION (Para 129)

(91) THAT FOUR BEDS FOR EVERY 40 BEDS SHOULD BE AVAILABLE FOR THE TREATMENT OF ACUTELY ILL CHILDREN (Para 129)

(92) THAT ARRANGEMENTS BE MADE FOR MOTHERS TO STAY IN THE HOSPITAL CLOSE TO THE CHILDREN WARDS WITH SUFFICIENT FACILITIES FOR TOILET AND CHANGING ROOMS (Para 129)

(93) THAT PREMATURE BABIES SHOULD BE TREATED IN PAEDIATRICS UNIT, EQUIPPED FOR IT (Para 129)

- (94) THAT PAEDIATRIC SURGICAL DEPARTMENT SHOULD BE DEVELOPED WITH PROPER EQUIPMENT AND STAFF IN KALAVATI SARAN HOSPITAL, AIIMS/SAFDARJANG COMPLEX AND MAULANA AZAD COMPLEX (Para 129)
- (95) THAT NURSES' RESIDENTIAL ACCOMMODATION SHOULD FIRST BE PROVIDED AS A PRIORITY BEFORE ADDITIONAL BED. STRENGTH IS SANCTIONED IN ANY HOSPITAL (Para 130)
- (96) THAT ALL HOSPITALS SHOULD EXPAND FACILITIES FOR TRAINING OF NURSES (Para 130)
- (97) THAT THE AIIMS SHOULD START A NURSING TRAINING SCHOOL/COLLEGE (Para 130)
- (98) THAT THE DELHI COLLEGE OF NURSING SHOULD FORM AN INTEGRAL PART OF THE AIIMS OR ALTERNATIVELY BUILT IN CONJUNCTION WITH WILLINGDON HOSPITAL COMPLEX (Para 130)
- (99) THAT MARRIED NURSES SHOULD BE ENGAGED FOR PART-TIME DUTIES AND RESIDENTIAL ACCOMMODATION PROVIDED NEAR THE HOSPITAL WHERE-EVER POSSIBLE (Para 130)
- (100) THAT STUDENT NURSES BE NOT SOLELY RESPONSIBLE FOR PATIENT CARE ESPECIALLY ON THE NIGHT SHIFT (Para 130)

- (101) THAT THERE SHOULD BE SUFFICIENT AUXILIARY PERSONNEL DESIGNATED AS PRACTICAL NURSES OR WARD ORDERLIES WITH PROPER TRAINING TO PERFORM AS MUCH UNSKILLED WORK AS POSSIBLE (Para 130)
- (102) THAT THE NURSING SUPERINTENDENT SHOULD HAVE MORE EFFECTIVE CONTROL OVER THE WARDS/OPERATION THEATRE ETC. TO ENSURE MAINTENANCE OF SANITATION CLEANLINESS AND WARD DISCIPLINE (Para 130)
- (103) THAT THE DENTAL SERVICE IN ALL THE HOSPITALS SHOULD BE ORGANISED TO MEET THE BASIC NEEDS OF THE POPULATION IT SERVES (Para 131)
- (104) THAT IN ADDITION TO THE STRENGTHENING OF ORAL SURGERY SERVICE, IT WOULD BE DESIRABLE TO SET UP THE PROSTHETIC SECTION IN THE DENTAL DEPARTMENT OF HOSPITALS (Para 131)
- (105) THAT DENTURES SHOULD BE MADE AVAILABLE AT SUBSIDIZED RATES (Para 131)

Surgical Service

- Prosthetic Workshop (105-A) THAT A PROSTHETIC WORKSHOP BE ESTABLISHED TO MEET THE REQUIREMENTS OF SURGICAL APPLIANCES OF ALL HOSPITALS IN DELHI.

Maternity  
Child Health &  
Obstetrics.

(106) THAT OBSTETRIC SERVICE AS A COMMUNITY HEALTH PROGRAMME SHOULD BE UNIFIED BY A CLOSER COLLABORATION OF DIFFERENT AGENCIES AND THE HOSPITALS UNDERTAKING THIS SERVICE IN THE UNION TERRITORY OF DELHI (Para 135)

(107) THAT EMPHASIS SHOULD BE ON DOMICILIARY CARE BASED ON THE ZONAL AND/OR AREA HOSPITALS (Para 135)

(108) THAT FAMILY WELFARE PLANNING AND SOCIAL OBSTETRICS SHOULD FORM AN INTEGRAL PART OF MATERNAL AND CHILD HEALTH SERVICES (para 135)

Operation  
Theatre.

(109) THAT THE ANAESTHESIOLOGIST SHOULD BE IN OVERALL CHARGE OF OPERATION THEATRE (Para 133)

(110) THAT THE NUMBER OF OPERATION THEATRES BE PROVIDED ON THE SCALE OF ONE THEATRE FOR EVERY 50 GENERAL SURGICAL BEDS. IN ADDITION FOR SEPTIC WORK, EMERGENCY AND ACCIDENT SERVICE, OUTPATIENTS, GYNAECOLOGY, EYE, ENT & OTHER SPECIALITIES THERE SHOULD BE SEPARATE THEATRES (Para 136)

(111) THAT BACTERIOLOGICAL EXAMINATIONS FOR STERILITY OF THEATRE AIR, EQUIPMENT,

FLOOR AND FIXTURES SHOULD BE CARRIED OUT  
EVERY FORTNIGHT AND PROPER RECORDS  
MAINTAINED (Para 136)

(112) THAT NEW OPERATION THEATRES SHOULD BE  
PLANNED BEARING IN MIND CLEAN AND DIRTY  
ZONES WITH AIR LOCKS AND SUITABLE ANCILLARY  
ROOMS FOR STORES AND SERVICES (Para 136)

(113) THAT OPERATION THEATRES SHOULD HAVE  
CENTRAL STERILE SUPPLY SERVICE & CENTRAL  
PIPED SYSTEM FOR MEDICAL GASES AND CENTRAL  
SUCTION (Para 136)

(114) THAT RECOVERY ROOMS SHOULD BE LOCATED IN  
THE THEATRE BLOCK (Para 136)

(115) THAT ADEQUATE SAFETY MEASURE BE INSTALLED  
AGAINST FIRE, EXPLOSION ETC. (Para 136)

(116) THAT ROUND THE CLOCK SERVICE UNDER THE  
CHARGE OF TRAINED OPERATION THEATRE  
TECHNICIAN SHOULD BE PROVIDED (Para 136)

(117) THAT THE WHOLE THEATRE BLOCK SHOULD  
PREFERABLY BE CENTRALLY AIR CONDITIONED  
POSITIVE PRESSURE AND 100% AIR REPLACEMENT  
WITH  
AND EQUIPPED WITH GERMICIDAL ULTRA VIOLET  
LAMP (Para 136)

Central Sterile  
Supply.

(118) THAT THE IRWIN, LADY HARDINGE & HINDU RAO  
HOSPITALS SHOULD HAVE A CENTRAL STERILE  
SUPPLY SERVICE (Para 137)



- (119) THAT THE CENTRAL STERILISATION SERVICE  
IN THE GOBIND BALLABH PANT HOSPITAL  
SHOULD BE COMMISSIONED (Para 137)
- (120) THAT IN ALL HOSPITALS BACTERIOLOGICAL  
STERILITY OF THE SUPPLIES FROM CENTRAL  
STERILISATION DEPARTMENT SHOULD BE  
CONSTANTLY AND REGULARLY CHECKED TO ENSURE  
PROPER QUALITY AND RECORDED. (Para 137)
- (121) THAT EACH HOSPITAL SHOULD HAVE A STANDING  
COMMITTEE FOR PREVENTION OF HOSPITAL  
INFECTION (Para 139)
- (122) THAT THERE SHOULD BE A DESIGNATED INFECTION  
CONTROL SISTER TO ASSIST THE COMMITTEE.  
(Para 139)
- (123) THAT ALL HOSPITALS SHOULD ORGANISE ON  
PROPER LINES MEDICAL RECORD KEEPING FOR  
INPATIENT AND OUTPATIENT (Para 140)
- (124) THAT THE FORMS USED IN HOSPITALS SHOULD  
BE STANDARDISED (Para 140)
- (125) THAT MEDICAL RECORDS SHOULD BE RETAINED  
FOR A MINIMUM PERIOD OF 25 YEARS FOLLOWING  
THE LAST VISIT OF A PATIENT. (Para 140)
- (126) THAT THE MEDICAL RECORD DEPARTMENT SHOULD  
DEVELOP A REFERENCE LIBRARY WHICH SHOULD  
BE KEPT OPEN FOR ATLEAST 12 HOURS DURING  
THE DAY. (Para 140)

Hospital  
Infection.

Medical  
Records.

- (127) THAT MEDICAL RECORD SECTION BE STARTED FORTHWITH IN WILLINGDON, LADY HARDINGE AND HINDU RAO HOSPITALS. (Para 140)
- (128) THAT THE DEFICIENCIES OF SPACE AND STAFF IN THE MEDICAL RECORD DEPARTMENT IN THE IRWIN HOSPITAL BE REMEDIED. (Para 140)
- (129) THAT CENTRAL PHOTOGRAPHIC DEPARTMENT OF THE HOSPITAL SHOULD BE LOCATED IN THE MEDICAL RECORD LIBRARY. (Para 140)
- Patient Care evaluation. (130) THAT IN EACH HOSPITAL A MEDICAL AUDIT COMMITTEE SHOULD BE SET UP FORTHWITH. (Para 141).
- (131) THAT IN EACH HOSPITAL MORTALITY REVIEW SHOULD BE CARRIED OUT. (Para 141)
- Autopsy. (132) THAT GOVERNMENT MAY ENACT SUITABLE LEGISLATION TO ENABLE AUTOPSY TO BE PERFORMED. (Para 142)
- (133) THAT THE PROVISIONS OF CORONER'S ACT BE MADE APPLICABLE IN DELHI. (Para 142)
- Education & training. (134) THAT THE REQUIREMENTS OF STAFF, PHYSICAL FACILITIES AND EQUIPMENT OF TEACHING HOSPITALS SHOULD BE BROUGHT UPTO STANDARD. (Para 144)
- (135) THAT SPECIAL SHORT TERM REFRESHER COURSES AND CLINICS BE ORGANISED. (Para 145)

- (136) THAT DEPARTMENT OF PREVENTIVE MEDICINE SHOULD BE ESTABLISHED IN HOSPITALS.

(Para 146)

- (137) THAT HEALTH EDUCATION FACILITIES BE AVAILABLE IN HOSPITALS. (Para 147)

- (138) THAT TRAINING FACILITIES FOR MEDICAL, LAY AND OTHER HOSPITALS ADMINISTRATORS BE AUGMENTED. (Para 148)

- (139) THAT INSERVICE AND ORIENTATION TRAINING BE IMPARTED FOR HOSPITAL STAFF. (Para 149)

- (140) THAT ARRANGEMENTS BE MADE FOR TRAINING NURSES IN SPECIAL DISCIPLINES. (Para 150)

Medical  
staffing.

- (141) THAT QUALIFIED AND EXPERIENCED PERSONNEL BE APPOINTED AS SPECIALISTS. (Para 154)

- (142) THAT THE SUPERTIME GRADE I POSTS IN THE SCALE OF Rs.1800-2250 AT G.B. PANT HOSPITAL SHOULD BE PLACED IN THE GENERAL POOL AND SHOULD BE FILLED BY SELECTION OF VIRTUE OF QUALIFICATIONS, EXPERIENCE AND SENIORITY. THE HEADS OF DEPARTMENTS/UNITS IN THE G.B. PANT HOSPITAL SHOULD NORMALLY BE IN SUPERTIME GRADE II PROFESSORIAL GRADE. (Para 154)

- (143) THAT THERE IS NEED FOR SPECIALISTS IN THE PROFESSORIAL GRADE IN THE WILLINGDON AND SAFDARJANG HOSPITALS. (Para 154)

- (144) THAT THE DIFFERENT DEPARTMENTS BE STRENGTHENED BY APPOINTMENT OF REGISTRARS WITH POST-GRADUATE QUALIFICATIONS ON A TENURE BASIS OF 3 YEARS. (Para 155)
- (145) THAT THE POSTGRADUATE STUDENTS REGISTERED FOR STUDIES BE GIVEN PATIENT CARE RESPONSIBILITY AND DESIGNATED AS 'RESIDENTS'. (Para 155)
- (146) THAT THE NUMBER OF POSTS OF GENERAL DUTY MEDICAL OFFICERS IN THE HOSPITALS SHOULD BE REDUCED TO THE MINIMUM. (Para 155)
- (147) THAT THE CASUALTY DEPARTMENT SHOULD FUNCTION UNDER THE DIRECT SUPERVISION OF THREE DIFFERENT OFFICERS, MEDICAL, SURGICAL AND MEDICOLEGAL AND THE RESPONSIBILITY OF PATIENT CARE SHOULD DEVOLVE ON THE HEAD OF THE UNIT CONCERNED. THE EMERGENCY SERVICE SHOULD BE MANNED BY EXPERIENCED MEDICAL OFFICERS WITH POST-GRADUATE QUALIFICATIONS. (Para 156)
- (148) THAT THE HONORARIES SHOULD BE SUBJECT TO SOME RULES AND REGULATIONS AS PAID MEMBERS. (Para 152)
- (149) THAT EMERITUS CONSULTANTS SHOULD VISIT HOSPITAL WHEN CALLED FOR ADVICE. (Para 153)

Operational  
Research.

(150) THAT OPERATIONAL RESEARCH TO MAKE THE MOST EFFECTIVE USE OF AVAILABLE RESOURCES IN TERMS OF BEDS AND MNPOWER BE CARRIED OUT. (Para 157)

(151) THAT WORK STUDY UNITS SHOULD GO INTO THE STAFFING PATTERN (OTHER THAN MEDICAL) IN HOSPITALS. (Para 157)

Medical  
negligence.

(152) THAT DOCTORS WORKING IN DELHI HOSPITALS SHOULD BE ASKED TO PURCHASE PHYSICIANS LIABILITY INSURANCE, CALLED MEDICAL INSURANCE. (Para 158)

(153) THAT A COURSE OF LECTURES ON MEDICAL NEGLIGENCE MAY BE ARRANGED FOR ALL THE STAFF OF THE DELHI HOSPITALS BY THE RESPECTIVE SUPERINTENDENTS. (Para 158)

Coordination:

(154) THAT THE EXISTING COMMITTEE OF MEDICAL SUPERINTENDENTS OF DELHI HOSPITALS SHOULD FUNCTION REGULARLY. (Para 161)

A.I.I.M.S./  
Safdarjang.

(155) THAT THERE SHOULD BE INTEGRATION OF THE A.I.I.M.S. HOSPITAL AND THE SAFDARJANG HOSPITAL UNDER ONE MANAGEMENT. (Para 162)

(156) THAT THE DETAILED SCHEME FOR THE DEPLOYMENT OF PERSONNEL, RATIONALIZATION OF DEPARTMENTS,

LOCATION OF SPECIALITIES ETC. ETC. SHOULD BE WORKED OUT BY A HIGH POWER COMMITTEE CONSISTING OF EXPERTS FAMILIAR WITH THE WORKING OF THE TWO INSTITUTIONS. (Para 164)

Maulana Azad Complex: (157)

THAT THERE SHOULD BE INTEGRATION OF THE MAULANA AZAD MEDICAL COLLEGE, THE IRWIN AND THE GOBIND BALLABH PANT HOSPITALS FOR SERVICE, EDUCATION AND RESEARCH UNDER ONE MANAGEMENT. (Para 165)

Willingdon Hospital/  
Lady Hardinge:

(158) THAT THE WILLINGDON HOSPITAL SHOULD SERVE AS A CLINICAL CENTRE FOR TEACHING OF STUDENTS OF THE LADY HARDINGE MEDICAL COLLEGE AND THE STAFF AND PHYSICAL FACILITIES SHOULD BE BROUGHT UP TO THE STANDARDS OF A TEACHING HOSPITAL. (Para 166)

Development of specialities: (159)

THAT CERTAIN SPECIAL DISCIPLINES SHOULD BE DEVELOPED IN SELECTED HOSPITALS ON REGIONAL BASIS. (Para 167)

(160) THAT IN FUTURE THE LOCATION OF A SPECIALITY IN ANY HOSPITAL SHOULD BE ON THE RECOMMENDATIONS OF THE TECHNICAL COMMITTEE OF THE REGIONAL BOARD. (Para 190)

Coronary Care Unit:

(161) THAT CORONARY CARE UNIT PROPERLY EQUIPPED AND ADEQUATELY STAFFED SHOULD BE ESTABLISHED IN THE THREE COMPLEXES VIZ. LADY HARDINGE/ WILLINGDON, M.I.I.M.S./SAFDARJANG AND MAULANA AZAD GROUP. (Para 172)

Emergency &  
accident  
service:

- (162) THAT THERE SHOULD BE A CENTRAL CONTROL ROOM FOR THE EMERGENCY AND ACCIDENT SERVICE. (Para 177)
- (163) THAT AMBULANCE SERVICE SHOULD BE CENTRALISED WITH ATLEAST 3 SUB-STATIONS IN DIFFERENT PARTS OF DELHI AND THAT WORKSHOP FACILITIES BE PROVIDED TO KEEP THE FLEET ON ROAD.  
(Para 177)
- (164) THAT THE AMBULANCES BE FITTED WITH WALKIE-TALKIE WIRELESS SERVICE. (Para 177)
- (165) THAT EMERGENCY DEPARTMENTS IN WILLINGDON, SAFDARJANG, LADY HARDINGE, IRWIN AND HINDU RAO HOSPITALS SHOULD BE PROPERLY EQUIPPED AND STAFFED TO HANDLE ALL ACCIDENTS AND EMERGENCY CASES. (Para 178)
- (166) THAT TRAUMA SURGERY UNIT SHOULD BE ORGANISED IN ALL HOSPITALS. (Para 180)
- (167) THAT NEURO-SURGERY UNITS FOR TREATMENT OF HEAD INJURY CASES BE FULLY EQUIPPED IN THE A.I.I.M.S., THE WILLINGDON AND THE PANT HOSPITALS. (Para 180)
- (168) THAT EVERY MAJOR HOSPITAL SHOULD HAVE DISASTER PLAN. (Para 181)
- (169) THAT THE BLOOD BANK SERVICE SHOULD BE CENTRALISED COLLECTING AND DISPENSING UNITS UNDER THE BLOOD BANK OFFICER SHOULD CONTINUE IN EACH HOSPITAL. (Para 182)

Medico-  
legal:

- (170) THAT FOR MEDICOLEGAL WORK DELHI MAY BE DIVIDED INTO THREE DISTRICTS AND EACH DISTRICT SHOULD HANDLE THE WORK ARISING IN ITS ZONE. (Para 183)
- (171) THAT ALL MEDICAL OFFICERS IN THE FORENSIC MEDICINE DEPARTMENT OF THE MAULANA AZAD MEDICAL COLLEGE AND ALL-INDIA INSTITUTE OF MEDICAL SCIENCES BE AUTHORISED BY DELHI ADMINISTRATION TO PERFORM MEDICO-LEGAL POST-MORTEMS. (Para 183)

C.G.H.S.

- (172) THAT ALL-INDIA INSTITUTE OF MEDICAL SCIENCES SHOULD BE RECOGNISED AS A REFERRAL HOSPITAL FOR THE BENEFICIARIES OF C.G.H.S. FOR THOSE FACILITIES WHICH DO NOT EXIST IN THE WILLINGDON AND SAFDARJANG HOSPITALS. (Para 184)

Planning & Development:

- (173) THAT CO-ORDINATION OF HEALTH PROGRAMMES OF THE VARIOUS ADMINISTRATIVE AUTHORITIES IS ABSOLUTELY NECESSARY. (Para 187)
- (174) THAT A HIGH POWER REGIONAL HEALTH BOARD SHOULD BE SET UP UNDER THE CHAIRMANSHIP OF UNION HEALTH SECRETARY TO CO-ORDINATE THE HOSPITAL AND HEALTH SERVICES OF DIFFERENT ADMINISTRATIVE UNITS. (Para 188)
- (175) THAT THE TECHNICAL COMMITTEE BE APPOINTED TO ADVISE THE REGIONAL HOSPITAL BOARD ON  
all



ALL TECHNICAL MATTERS. (Para 190)

- (176) THAT THE SCHEME FOR REORGANIZATION AND ZONAL DISTRIBUTION OF HEALTH SERVICES IN DELHI RECOMMENDED BY THE MINISTRY OF HEALTH COMMITTEE IN 1963 SHOULD BE IMPLEMENTED.

(Para 194)

- (177) THAT SERVICES OF GENERAL PRACTITIONERS MAY BE UTILISED IN THE ORGANISATION OF COMPREHENSIVE HEALTH SERVICES. (Para 195)

- (178) THAT REGIONAL BOARD SHOULD CONSIDER ALL DEVELOPMENT PLANS FOR HEALTH CARE BEFORE INCLUSION IN THE DEVELOPMENT PROGRAMME.

(Para 208)

- (179) THAT TOP PRIORITY SHOULD BE ACCORDED TO SANCTION FUNDS TO IMPROVE LABORATORY AND RADIOLOGICAL SERVICES, OPERATION THEATRES, CENTRAL SUPPLY SERVICE AND RESIDENTIAL ACCOMMODATION FOR ESSENTIAL STAFF. (Para 204)

General  
Hospitals.

- (180) THAT THE HINDU RAO HOSPITAL SHOULD BE PLANNED TO DEVELOP INTO A HOSPITAL OF 500-750 BEDS WITH ALL SUPPORTING SERVICES.

(Para 204)

- (181) THAT THE SHAHDARA GENERAL HOSPITAL BE DEVELOPED INTO A GENERAL HOSPITAL UPTO 500 BEDS WITH ALL SUPPORTING SERVICES.

(Para 197)

(182) THAT A NEW GENERAL HOSPITAL OF 500 BEDS BE CONSTRUCTED IN WEST DELHI AS A PRIORITY.

(Para 197)

(183) THAT PRIORITY SHOULD BE GIVEN TO THE DEVELOPMENT OF HEALTH CENTRES, POLYCLINICS, INTERMEDIATE HOSPITALS AND NO FURTHER BEDS BE ADDED TO THE EXISTING HOSPITALS. (Para 197)

Health  
economics:

(184) THAT STUDIES ON TRENDS OF HEALTH EXPENDITURE, EXTENT OF HEALTH SERVICES, REASONS FOR DIFFERENCES ETC. ETC. SHOULD BE UNDERTAKEN.

(Para 210)

Health Insurance: (185) THAT THE HEALTH SERVICES CAN BE FURTHER EXPANDED BY THE INTRODUCTION OF A HEALTH INSURANCE SCHEME. (Para 211)

Accreditation: (186) THAT A HOSPITAL ACCREDITATION COUNCIL BE APPOINTED. (Para 212)

(187) THAT THE SPECIALISTS BE GIVEN RECOGNITION BY D.G.H.S. (Para 212)

Merit Award: (188) THAT GOVERNMENT SHOULD CONSIDER THE GRANT OF MERIT AWARD TO PERSONS OF OUTSTANDING MERIT. (Para 214)

Expert  
Advice:

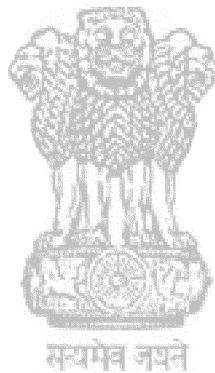
(189) THAT THE SERVICES OF INTERNATIONAL AGENCIES LIKE W.H.O. BE AVAILED OF FOR CONSULTANT SERVICES IN THE ORGANISATION OF THE REGIONAL HEALTH BOARD AND SERVICES. (Para 215)

Review &  
implementa-  
tion Committee:

(190) THAT THERE SHOULD BE A HOSPITAL  
REVIEW AND IMPLEMENTATION COMMITTEE  
TO FOLLOW UP THESE RECOMMENDATIONS.

(191) The Committee would like to emphasise  
that the success of implementation of  
the above recommendations would  
ultimately depend upon the creation  
of a healthy and harmonious doctor-  
patient relationship.

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## CHAPTER - 3

### SURVEY

#### 3.1 Evolution of Hospital Services in Delhi and Central Government Health Scheme.

##### General

1. The Union Territory of Delhi has an area of 573 sq. miles. For administrative convenience it comprises of four units viz. Delhi Municipal Corporation (DMC)(Rural), D.M.C. (Urban), New Delhi and Delhi Cantt. As per 1961 census the total population of Delhi was 26.59 lakhs of which 11.25% was rural and the balance in 3 urban areas, D.M.C. (Urban ) 77 .55%, New Delhi 9.83% and Delhi Cantt. 1.36%.

2. In the past 16 years, the population of Delhi has doubled from 17.44 lakhs in 1951 to about 34 lakhs in 1967, with an annual growth of 6.4%. Scores of new colonies or townships have grown and continue to grow round about Old and New Delhi. The rural area is being progressively eroded by urban expansion. During this period there has been substantial addition to and progressive improvement in health services but these have not kept pace with the needs of the growing population particularly in the newly developed residential colonies.

3. A multiplicity of agencies provide hospital and specialist care in Delhi viz. the Central Government, autonomous bodies under the Ministry of Health, the Delhi Administration, the Delhi Municipal Corporation, the New Delhi Municipal Committee, and the voluntary and private organisations. The hospitals considered and priv

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in this report are as follows:-

Willington Hospital and Nursing Home: This was established in 1934-35 to meet the needs of high officials of the Government and well-to-do citizens. It had 50 beds (Hospital 32 and Nursing Home 18). The hospital was maintained till January 1954 by the New Delhi Municipal Committee when it was taken over by the Government of India, Ministry of Health. It has now 552 beds including 58 Nursing Home beds (46 general and 12 obstetrics).

Safdarjung Hospital: This hospital had been put up by the American forces in India during the Second World War and on the termination of hostilities, was taken over by the Government of India to serve the needs of the civil population residing in Delhi South and adjoining rural sector. It functioned as an Annexe of the Irwin Hospital up to 1954 when it was taken over by the Government of India, Ministry of Health, for providing indoor facilities for Government servants and their families under the C.G.H.S. and also to serve as the hospital for All India Institute of Medical Sciences. At present it had 1148 beds + 174 bassinets.

Lady Harding Medical College & Hospital: This was set up in 1916 as an autonomous institution with the object of providing medical education for girls and treatment of women and children. The hospital is managed by a Board of Administration with the Director General of Health Services as its Chairman. The hospital has now 567 beds.

Kalavati Saran Children's Hospital: This was established

Medical College and Hospital. It has now a bed strength of 234. It is an associate paediatrics hospital of the Lady Hardinge Medical College and Hospital and has its own Governing Body with the Director General of Health Services as the Chairman.

Irwin Hospital: This hospital was established in 1936 by the Delhi Administration with 300 beds and was designed to meet the requirements of Delhi population at that time. During the years beds have been progressively added to meet growing demands and has now reached a bed strength of 1068. The Maulana Azad Medical College was established in 1958 for which this hospital is now the main teaching hospital.

Govind Ballabh Pant Hospital: Established by the Delhi Administration in 1964, this hospital is located in the campus of the Irwin Hospital and is meant exclusively for the specialities of cardiology, cardiac surgery, neurology, neuro-surgery and psychiatry. At present it has a bed strength of 258.

All India Institute of Medical Sciences: This Institute was established in 1956 as an Autonomous Body, with the object of providing post-graduate medical education and research in different disciplines. It also provides for under-graduate training. Originally, the Safdarjang Hospital was expected to be the attached hospital for the All India Institute of Medical Sciences. The Institute now has a hospital of its own with 560 beds distributed to various medico-surgical disciplines.

Hindu Rao Hospital: This hospital is situated in the Civil Lines area and was commissioned as a temporary hospital in 1911 for Europeans. Up to 1947, it had only 16 beds out of which 12 were paying beds in special rooms and 4 were free beds. It functioned more or less as a Nursing Home. In 1958, the control of this hospital changed hands from Delhi Administration to Delhi Municipal Corporation. During the past few years, additional beds have been added and now this is the main general hospital in the North Delhi with only 306 beds.

Silver Jubilee Tuberculosis Hospital: This institution was started in 1935. In 1946, accommodation was available for 135 beds only. After Independence, the number of beds has been progressively increased. Now it has 1113 beds and is under the administrative control of Delhi Municipal Corporation.

Infectious Diseases Hospital: In 1946, the infectious Diseases Hospital had two wards of 20 beds each and a few rooms for isolation of communicable diseases. It had at present an accommodation for 175 beds and is under the administrative control of Delhi Municipal Corporation.

Ram Swarup Tuberculosis Hospital, Mehrauli: This hospital, which is named after the donor of the Estate, was opened in South Delhi in 1953 with 100 beds and an out-patient department. The hospital is under the Tuberculosis Association of India. The Director General of Health Services is the Chairman of the Trust. It has 306 beds.

New Delhi Tuberculosis Clinic: This was established in 1940 by the Tuberculosis Association of India. It has an out-patient clinic with emphasis on domiciliary treatment and has 12 emergency beds.

Mental Hospital, Shahdara: This hospital was established by the Delhi Administration and started functioning in 1966. It has at present a bed strength of 160.

4. With the enactment of the Delhi Municipal Corporation Act in 1958, the control of all hospitals except Irwin, Police and Jail Hospitals administered by the Delhi Administration was transferred to the Delhi Municipal Corporation.

5. Of about 8,000 hospital beds in Delhi, the D.M.C. has a total complement of 2,232 beds located in the following institutions. Some are general hospitals, others cater exclusively to certain specialities like Obstetrics and Gynaecology, Tuberculosis and Infectious Diseases:

	No. of beds.
1. S.J. Tuberculosis Hospital (Kingsway Camp)	1113
2. Hindu Rao Hospital (Civil Lines)	306
3. I.D. Hospital (Kingsway Camp)	175
4. G.L. Maternity Hospital (Ajmeri Gate)	97
5. Shahdara General Hospital	50
6. Victoria Zangana Hospital (Daryaganj)	175
7. Colony Hospitals	269
8. Primary Health Centres	46

The six colonies viz. Kalkaji, Malaviya Nagar, Moti Nagar, Tilak Nagar, Patel Nagar and Lajpat Nagar



have a hospital each with a few maternity and general beds but without any radiological and laboratory services.

6. The Railways have a Central Hospital in the Connaught Circus area (Sector- 2 ) for the exclusive use of Railway employees and their families.

7. For insured industrial workers and their families (about 4 lakhs), the Employees State Insurance Corporation has separate medical care arrangements. ESIC is building a hospital of 924 beds in north west Delhi (Sector 3) for the exclusive use of insured persons and their families in Delhi.

8. The following hospitals are run by the voluntary organisations and private trusts:-

- i. St. Stephan's Hospital (Tis Hazari)
- ii. Holy Family Hospital (Okhla)
- iii. Shroff's Eye Hospital (Darya Ganj)
- iv) Sant Parmanand Eye Hospital (Civil Lines)
- v) Model Eye Hospital (Lajpat Nagar).
- vi) Sir Ganga Ram Hospital (Rajinder Nagar)
- vii) Jaisa Ram Hospital (Karol Bagh)
- viii) Delhi Maternity Hospital (Pusa Road)
- ix) Tirath Ram Shah Hospital & Nursing Home (Civil Lines)

In private Nursing Homes there are about 300 additional beds.

9. The catchment area for hospitals, is not confined to the area comprising the Union Territory of Delhi but extends up to about 80 - 1000 miles roundabout. Quite a substantial proportion

of beds is occupied by patients who come from neighbouring districts of the adjoining States of Punjab, Haryana, Rajasthan and U.P. Delhi has also a sizeable floating population, Foreign Missions and dignitaries who expect a better quality of service.

10. Two big institutions, Safdarjang hospital and the All India Institute of Medical Sciences hospital with a total bed strength of about 2000 have developed on either side of the road in South Delhi. The G.B. Pant Hospital with 258 beds has been located in the premises of the already overcrowded Irwin Hospital with 1068 beds. In West Delhi and North Delhi there is hardly any hospital cover. The colony hospitals are of in-significant nature. There is thus no equitable distribution of hospital facilities in Delhi. Existing hospitals have expanded and continue to expand without any consideration of the need of the population in the various sectors. Unsatisfactory communication service in certain parts of Delhi, particularly in outlying colonies, adds to the hardship of the people.

#### Central Government Health Scheme

11. The Central Government Health Scheme (CGHS) previously known as Contributory Health Services Scheme, was started in 1954 in Delhi and later extended to Bombay in 1963. It was stated at the time of introduction that the scheme was in the nature of a National Health Insurance Scheme. It was to replace the system of Medical Attendance Rules, the working of which had

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not proved satisfactory. Besides being expensive to the Government, it had led to a number of mal-practices. It was also unsatisfactory to the Government servants, as the employees had to incur expenditure for treatment initially and later seek reimbursement from the Government. Low paid Government employees could ill-afford to incur the initial expenditure and wait for months on end for settlement of claims. Families of all classes and class IV employees were not eligible for domiciliary treatment.

12. The C.G.H. Scheme seeks to provide more efficient and comprehensive medical service of the same scale for all Government servants and their families, the main aim being to give medical aid according to needs but to charge contribution according to means. The rate of contribution for beneficiaries ranges from 50 paise to Rs. 12/- per month according to the emoluments. The CGHS aims to ensure a continuity of care at the home, clinic and hospital. The services (promotional, preventive and curative) include:-

- Out-door treatment;
- Supply of necessary drugs;
- Laboratory and X-ray investigations;
- Domiciliary visit;
- Ambulance service;

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In-patient treatment;

Specialist care;

Antenatal care, confinement and post-natal care for women and well baby clinic;

Emergency treatment;

Supply of optical and dental aids at reasonable scheduled rates by the Government appointed opticians and dentists; and

Advice on Family Planning, including supply of free contraceptive appliances;

Health check up;

Immunisation, and preventive services.

13. The C.G.H.S. has been able to establish a well knit clinic and domiciliary service supported by specialist cover at the hospital out-patients, polyclinics and at the home of the patient, where required. The CGHS has no hospital of its own. However in-patient treatment is provided at the Safdarjang and Willingdon Hospitals. In addition to these two hospitals, for maternity cases, the Lady Hardinge, Victoria Znanana, Mrs. Girdhari Lal and Holy Family hospitals are utilised. The various Corporation and Municipal maternity and Child Welfare centres in the city are also made use of for confinement of cases either at the centre or at the residence of the patient. The hospitalisation rate under the C.G.H.S. during the year 1965-66 was

General cases.	1.6	per	thousand	beneficiaries.
Maternity cases	1.8	"	"	"
Tuberculosis cases	0.6	"	"	"

14. During the same period the CGHS provided at 58 (modern medicine 52, mobile 3, Ayurvedic 2 and Homoeopathic 1) dispensaries out-patient and domiciliary medical cover to beneficiaries consisting of Government servants (5,84,753) Pensioners (2,266) and public (509). The total attendance during the year was 66,46,144 i.e. an average daily attendance of 22,491 out of which one-third were new cases.

15. With the Chinese aggression in October, 1962 and later the confrontation with Pakistan in September, 1965 a drastic cut in the health services for the community became inevitable. The continuing restriction on health development plans has hampered the progress of the welfare scheme during the last few years. In spite of the demands for defence preparedness the Government has done its very best in the face of increasing population, rising costs and pressure on services to provide modern facilities.

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3.2 Basic data of Institutions and the Committees observations.

16. Basic Data - Willingdon Hospital -

This hospital has 552 beds including 58 nursing home beds. These are provided in 12 general wards and two wings of the Nursing Home. Some of the wards are located in the old barracks across the road.

The specialities are distributed as follows:-

	No. of beds.	No. of Units/ Teams for each Speciality	Composition of the Unit.
Surgery	116	3	1. Head of the Unit - 1
Medical	132	3	2. Asstt. Surgeon - 1
Orthopaedic	38	1	3. Registrar - 1
Eye	20	1	4. House-Surgeon - 3
E. N. T.	16	1	1. Head of the Unit - 1
Dermatology	13	1	2. Jr. Staff Surgeon - 1
Gynae. & Obst.	19	1	3. Registrar - 1
Paediatrics	33	1	4. House Surgeon - 1
Dental	-	-	
Psychotherapy and Psychiatry	32	1	
Emergency Service	25	1	

Total number of patients admitted during the year 1966 were -

General wards	- 12,082
Nursing Home	- 1,525

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Out-patient services are provided in the under-mentioned specialities:-

<u>Speciality</u>	<u>Daily attendance</u>		
	New	Old	Total
Medical	135	102	237
Surgical	122	92	214
Orthopaedics	26	19	45
E.N.T.	65	48	113
Eye	62	54	116
Skin	135	102	236
Gynae. & Obstetrics	14	11	25
Paediatric	41	31	72
Dental	72	54	126
Psychiatry	26	19	45
<b>Total:-</b>	<b>698</b>	<b>532</b>	<b>1230</b>

Laboratory Services - The work-load in this department and the staff posted are as under:-

Laboratory	<u>Average daily work Load</u>		<u>Staff posted</u>			
	<u>Out-patients</u>	<u>In patients</u>	<u>Medical</u>	<u>Para-Medical</u>	<u>Asstt.</u>	<u>Attdt. Sweeper</u>
(i) Clinical	363.6	Daily tests.	1	7	8	8
(ii) Haematological		"	2	3	7	4
(iii) Biochemical	360.0	specimens daily	NIL	4	1	2
(iv) Bacteriological	70.0	"	1	4	1	2
(v) Histopathological	9					
(iv) Serological	11	specimens per day	Staff as per Bacteriological: (No separate Deptt. staff.			

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Radiology: - The diagnostic department has 9 plants of which 4 are 15 M.A. units. On an average 250 x-rays are done daily. There are 6 medical officers, 10 Radiographers and dark room assistants and 2 nurses in the department.

Radio-therapy- The Department does not provide radio-therapy treatment except short wave diatherapy.

Operation-theatre: - The hospital has 4 main operation theatres + 1 minor + 1 casualty operation theatre.

There is a post-operative ward but no intensive care wards.

Maternity services - The maternity services are provided only in the Nursing Home where 12 beds are reserved. There is one labour room which is also use for operative work.

Emergency and accident service The service functions round the clock and has an emergency ward of 25 beds close to it.

Ambulance service - The hospital has only 2 ambulances. A driver and a stretcher bearer go with the ambulance. Both the ambulances are old and breakdowns are frequent.

Blood bank- The blood bank collects about 2,500 units during the year. More than two thirds are professional donors.



Medical audit - The Hospital has a central mortality review committee which meets once a fortnight.

Nursing service - The nursing services comprise of one matron, 2 sister tutors, 2 assistant matrons, 40 nursing sisters, 107 staff nurses and 60 student nurses. Residential accommodation for nurses is very inadequate.

Medical education - The hospital is attached to Lady Harding Medical College for teaching. The members of the hospital staff, however, have not been given any teaching designation. The hospital is also recognised for post-graduate training in M.D. (General medicine), M.S. (General surgery) and diploma in anaesthesia, radiology, paediatrics and dermatology. 32 post-graduate students are currently working in the hospital.

Nursing Home - Of the 58 beds 12 are reserved for obstetrics cases. The ratio between the admission for medical and surgical cases is 10:1. Most of these cases are emergency heart cases.

Drugs and stores - The expenditure on medicines is over Rs. 10 lakhs a year. No separate record of expenditure on drugs is maintained for out-patients.

Kitchen & Diet - Patients in the nursing home are charged Rs. 7 per day for diet, while in the general ward the food is given free and the cost of the diet is Rs. 2.50 per day per patient.

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Laundry - The linen is washed by dhobis who are full time hospital employees. A new laundry has been installed but has not started functioning.

Patients' welfare - The hospital does not have any dharamsala for the relatives of patients. Advisory committee is not functioning.

Central sterilization - Dressings, operation theatre linen, syringes and various sets etc. are sterilized in the Central Sterilization Department.

Physio-therapy - Two trained physio-therapists are attached to the hospital.

Maintenance service for repairs comprises of one electrician and one carpenter. Maintenance of the building is under the P.W.D.

Tube wells and generator are available for use in emergency.

Mortuary Two autopsies were performed during 1966 and 5 in 1967. There are no facilities for cold storage of dead bodies.

staff - The following staff is in position in the hospital:-

		Full time	Hon.
1) Medical including	Specialist	15	1
Specialist, General	G.D.M.Os.	35	-
Duty M.Os. Registrars	Registrars	19	-
& House Surgeons.	House Surge- ons.	34	-
2) Para-Medical		264	
3) Ancillary		508	
4) Ministerial		62	

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The para-medical staff have unions.

Standing orders - There are no standing orders.

Budget & Finance -

No. of beds	-	552
Total Budget	- Rs.	49,35,600
Total Estt. charges	-	27,04,000
Other charges.	-	5,37,200
Stores & equipment	-	16,94,400
Food	-	2,45,000
Medicines	-	7,34,400
Equipment	-	3,40,000
X-Rays	-	2,75,000
Furniture	-	1,00,000

Future Development Programme:-

The Hospital has a proposal to construct an additional 750 beds (500 general, 150 nursing home and 100 casualty beds) raising the bed strength to about 1200 beds, to develop specialities in Cardiology, Dermatology, Psychiatry, Pathology and Biochemistry; to improve basic needs of CGHS patients and public patients in general medicine and surgery; to upgrade ancillary services including central sterilisation service and laboratories; and to provide an efficient casualty service round the clock. A few of the items of capital outlay for the

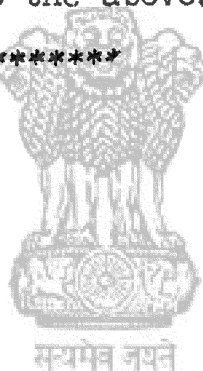
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Fourth Plan are as follows:

	<u>Rs. in lakhs</u>
i) Building for 360 general beds.	40
ii) Additional 90 Nursing Home Beds.	23
iii) Building for Central Sterilisation Supply - Radiology, Laboratories, Blood Bank, etc.	30
iv) A second hostel for nursing staff:	40
v) Geriatric Hospital	7

The cost of equipment in the laboratories  
etc. is in addition to the above.

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## 17. OBSERVATIONS

### Administrations:

The Medical Superintendent is also the Consultant-Physician in charge of one of the medical units on the general side and of the whole of the Nursing Home medical side. In addition, he has commitments for teaching both under-graduates and post-graduate and for research. He is assisted in the administration of the hospital by a Deputy Medical Superintendent, an Administrative Officer, an Accounts Officer, a Stores Officer and a Nursing Superintendent.

The Medical Officers working in this Hospital belong to three categories - the medical staff on the strength of the hospital, C.G.H.S. specialists to attend to C.G.H.S. beneficiaries and teaching staff of the medical and surgical units of the Lady Hardings Medical College. The CGHS unit is a referral centre for specialist's consultation for 29 CGHS dispensaries.

### Ambulance Service:

This is inadequate and unsatisfactory.

### Medical Stores:

The accounting procedure is unsatisfactory. Apart from refrigerators, no cold storage facilities are available. Proper arrangements for storage of inflammable articles and gas cylinders do not exist.

Pharmacy:

The pharmacy dispenses about 500 prescriptions a day. Intravenous solutions are not prepared.

Kitchens:

It is understood that health records of personnel working in the kitchen are kept but the same were not produced before the Committee. Some kitchen staff take the food to the wards for distribution. Only 2 food trollies have thermo-static control, and the remaining are ordinary trollies.

Emergency arrangements for water supply:

The tube wells provided for emergency water supply are not connected to the main reservoir.

General Discipline:

General discipline among all ranks leaves much to be desired.

Disposal of Refuse:

There is no incinerator in the hospital. The hospital waste is dumped into the public receptacles.

Mattress Sterilizations:

The hospital does not have mattress sterilizer and arrangements for disinfection of blankets are not available.

Information Centre:

There is no properly organised Central Enquiry Counter to answer enquiries.

Physical Facilities:

Buildings: Sanction for constructing a 360

bedded block appears to have been given. This is not desirable without first improving the essential facilities and efficiency of the institution. Better laboratory and diagnostic facilities, operation theatres, more quarters for nurses and other essential staff are inescapable pre-requisites to any plan of further expansion.

Staff: Clinical staff is inadequate at the supervisory level and the laboratory staff is also inadequate.

Equipment: Modern equipment for the operation theatres and other departments is inadequate and this is one of the most important priorities.

Laboratory and Radiological facilities and Blood Bank:

Laboratory Services: The 'Clinical Pathology' department has four units viz. morbid anatomy, clinical haematology, bio-chemistry and microbiology. The officer in charge of morbid anatomy also looks after the microbiology section in the absence of a microbiologist. Histopathology section takes about 6 days to report after the receipt of specimen. No frozen section service is provided. Some attempt is being made to undertake cytology work by this section but this is not satisfactory.

The clinical haematology unit has a heavy load. Haemoglobin estimates are done by Sahli's method and total and differential counts by routine pipette technique. No cogaluation tests are done, apart from clot retraction.

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The Microbiology laboratory has no trained bacteriologist in position and is essentially run by 4 technicians. The quality of work is sub-standard.

In the Bio-chemistry laboratory flame photometer was out of order. Serum electrolyte estimations are done by colorimetric method which is both time consuming and inaccurate. Basal metabolic rate (BMR) is being done in this laboratory in a room which is also the office of the Bio-chemist. BMR investigation is considered out of date.

The OPD clinical laboratory collects specimens and passes them to the main laboratory for examination.

The Clinical Pathology department has no stenographer.

Radiology Department

Only diagnostic facilities are available. Special investigations are undertaken the next day for inpatients and for outpatients, depending on priority, it takes on an average 8 days to do the investigations. 24 hour emergency service is offered by the department. X-ray photographs are sent to the wards or the out-patients, as the case may be, without reports. No record of the X-ray photographs is maintained in any department. The X-ray photographs are either taken by the patients or destroyed after 3-4 years. No stenographer is available in the department.



### Blood Banks

This is located away from the main hospital. It should preferably be near the out-patient and emergency and accident departments. No register is maintained to record post-transfusion reactions.

### Medical Service

Out-patient Department: All out-patient departments are located in the new building. There is no appointment system in the O.P.D. The attendance is quite heavy, which leads to overcrowding. Pharmacists are utilised for registration work which is a waste of technical manpower.

In-patients: A corridor connecting the O.P.D. with the main hospital is under construction. At present patients find it very difficult to reach their respective wards. One of the ambulances is reported to be used to carry the patients from O.P.D. to the wards. The medical wards in barracks are cut off from the main hospital by a busy road, with consequent delay in the transport of patients to and from the main hospital. There is no central admission office. It is not possible to find out whether a patient, who has been referred for admission, has been actually admitted or not. The enquiry counter in the hospital functions only during the day. The records with the enquiry clerk are not up-to-date. He has to ring up the ward on the internal telephone to get the necessary information whenever an enquiry is made.

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Paediatrics: There are no arrangements for paediatric surgery.

Cancer: Cancer cases are referred to the Safdarjang Hospital.

Dental: The Dental OPD handles all work except prosthetics.

Medical Records: There is no medical record library.

Continuity of Patient Care:

If the specialists in the OPD are also attached to the units in the hospital, there will be continuity of medical care and greater satisfaction to the patients.

Surgical Services:

The general standard of surgical service is not satisfactory. The absence of intensive care ward makes it difficult for the proper post-operative management of the cases. In view of the importance of this hospital, and the need for the surgical service to the Nursing Home patients and special ward patients, the existing facilities are considered inadequate. The present arrangements for treatment of septic and clean cases in the same theatre should be immediately discontinued.

There are three surgical units - one headed by a Neuro-Surgeon of a Consultant's status, who is also doing general surgery, one by the Associate Professor of the Lady Hardinge Medical College and one by a Specialist doing general surgery.

Work allotted to these units must be clearly defined and based on the training the Surgeons have received. The Neuro-Surgical team must confine its activities to neuro-surgical work. The general surgical work must be done by the other two general surgeons.

Operation Theatres:

Of the 4 operation theatres, 3 are functioning. One of them is shared between Gynaecology, Eye and Ent. The theatre earmarked for septic work is not functioning due to lack of equipment. The emergency theatre has also not been equipped so far. The hospital has no arrangements for the supply of hot and cold sterile water in the theatres. Because of the limited number of theatres, the operative work is carried out on all days and no wash day is possible. There are no air-locks.

Central Sterilization:

The central sterilization department is located in out-patients department and is under the charge of a surgeon. It was reported that the Microbiology Department of the hospital does periodic check up for sterility of the

supplies from this department.

It is, however, noticed that the Microbiologist is not in position and no regular records of sterility checks are maintained.

Obstetrics & Gynaecology:

Obstetric facilities are available only in the Nursing Home. Operative deliveries are also

done in the labour room as there is no separate operation theatre.

Emergency and Accident Service:

The casualty theatre is not equipped. The Emergency Department does not have facilities for laboratory services.

Specialist Care:

With the existing staff and the physical facilities available, there is no possibility of any other higher disciplines being developed except neuro-surgery and general surgery.

Urology:

For urology a minor operation theatre is used for examination and treatment.

The question of developing other disciplines in collaboration with the Lady Hardinge Medical College to function as a sector hospital and as a teaching and training centre should be considered. The existing staff, therefore, should not take on other work of higher nature for which they are not trained.

Coordination:

In the present stage of development of the Willingdon Hospital, the question of using regular consultant service from other well-developed hospitals should be taken up for consideration. Coordination with other institutions, therefore, becomes very important to give the best of medical and surgical care to the patients admitted in

this hospital.

Education and Training:

As this hospital is a clinical centre for the training of under-graduates of Lady Harding Medical College, it is necessary to improve the existing facilities in this institution such as laboratory and other diagnostic services, clinical lecture theatres, seminar rooms, cloak rooms for the students, library, post-mortem facilities. It is also necessary that the staff that are posted there are adequately qualified and experienced to be designated as teachers, so that an academic atmosphere exists and the hospital really functions for education, research and good patient care.

Continuing education for the staff that are working there, CCHS medical officers and general practitioners should be organised.

The existing facilities for post-graduate students in various disciplines are not adequate. Residential accommodation is inadequate. The patient care responsibility should be entrusted to the post-graduates and they should be designated as Residents.

In view of the unique nature of this institution, with heavy nursing home responsibility, it should not be overloaded with additional beds. Priority should be given to streamlining the present administration and improving the existing facilities wherever there is deficiency, to the highest standard.

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### SAFDARJANG HOSPITAL

18. Basic data: The Hospital has 1148 beds plus 174 bassinets. These are provided in 30 wards for adults and children and 2 nurseries for new borns.

The number of beds in the different specialities and the number of units in each speciality are as follows:-

	<u>No. of beds.</u>	<u>No. of Units/ Teams for each speciality</u>	<u>Composition of the Units</u>
Surgery	177	4	} One head of Unit, one Asstt. Surgeon, Registrars 1-2 House Surgeon, 2-3
Medical	170	5	
Orthopaedic	150	1	
Eye	28	3	
E.N.T.	18	1	
Dermatology	7	1	
Gynae & Obst.	300	3	
Paediatrics	150	3	
Cancer	60	4	Under Surgical Unit.
Plastic Surgery and burns	54	1	
Tetanus	8	1	Under Surgical Unit.
Emergency	20	9	
Neo-Natal	174	1	
Bassinets			
Recovery Room	6	1	

The number of admissions during the year 1966 was 50,449.

OUTPATIENT SERVICES:

The number of new and old cases in the different specialities is as follows:-

Attendance:

<u>Speciality</u>	<u>Attendance during the year</u>			<u>Daily average</u>
	<u>New</u>	<u>Old</u>	<u>Total</u>	
Casualty	64,634	-	64,634	178
Surgery	22,706	35,053	57,759	192
Medicine	37,807	77,472	1,15,279	384
Paediatrics	30,166	64,594	94,760	316
Orthopaedics	20,851	24,644	45,495	150
Psychiatry	1,695	7,151	8,846	29
Dental	8,318	3,511	11,829	39
E.N.T.	10,590	7,289	17,879	60
Eye	6,121	8,163	14,284	47
V.D.	6,272	5,756	12,028	40
Dermatology	20,738	26,013	46,751	156
Gynae.	16,678	17,431	34,109	114
Obst. A.N.	8,256	22,390	30,646	102
P.N.	1,132	2,391	3,463	11
Burns, Plastic & Maxillo-facial surgery	2,132	2,673	5,496	18
				<u>1236</u>

The registration for the out-patients is done department-wise. There is no reception or enquiry in the O.P.D.

LABORATORY SERVICES:

The average work load and the staff posted in the different sections of the laboratory are as under:-

	<u>Average daily work load</u>		<u>Staff posted</u>			
	<u>Out- Patients</u>	<u>In- patients</u>	<u>Medical</u>	<u>Para-Medical Tech.</u>	<u>Asstt.</u>	<u>Atd.</u>
<u>Clinical</u>						
Main:	24	8	-	1	1	1
Medical O.P.D.	183	-	-	3	2	2
Emergency	-	142	-	4	1	-
Bacteriological	30.1	81.1	1	9	2	3
Serological	3	12	Staff in Bacteriology Lab. does this work also.			
Histo-Pathological	10	26				
Histocytological	12	3	-	1	1	1
Biochemical Genl.	50	75	-	-	5	2
Cancer	14	30	-	-	5	3

RADIOLOGY DEPARTMENT

It has both diagnostic and treatment sections. In the diagnostic section about 400 X-rays are done daily. It has 14 X-ray machines ranging from 15 MA to 1000 MA. The Department has also a Dental X-ray Unit, and an image intensifier. Out of these, 4 X-ray machines are not working.

The staff consists of five Medical Officers, 12 Radiographers, 3 X-ray Assistants and 8 dark-room



Assistants. The department provides 24 hours service.

RADIOTHERAPY:

In addition to short-wave dia-thermy, superficial and deep-X-ray, the department also provides Cobalt Therapy.

OPERATION THEATRES:

Of the 17 operation theatres, five are earmarked as operation theatres (main), one minor, one for cancer, 4 in maternity Unit, 3 in Orthopaedic Unit, 2 for the Plastic Surgery and one for the burns unit. A total of 26,372 operations were performed during the year. A new five storeyed operating suite having fourteen theatres is under construction.

Post operative ward

There is a post operative ward of 6 beds with round the clock medical and nursing services.

There is no intensive care ward.

Maternity Service:

The Obstetrics and Gynaecology department has 300 beds with attached labour rooms and operation theatres.

Emergency and Accident Service.

The Emergency & Accident Service consists of the main Casualty Department with Emergency Ward and 3 Sub-Emergency Departments; viz.

- a. Gynae. & Maternity Casualty;
- b. Orthopaedic Casualty; and
- c. Burns and Maxillo-facial injuries.

The General Casualty has a separate 20 bedded ward with round the clock facilities of cardio-respiratory, resuscitation and blood bank services. The admissions from other casualties are made in the respective wards.

Ambulance Services:

There are 5 ambulances. Each ambulance has a driver and a stretcher-bearer.

Blood Bank:

The Hospital Blood Bank collected over 5,160 units of blood during the year. 80% of these were from the professional donors.

Medical audit:

There is no Medical Audit in the Hospital. The autopsy rate is very low.

Nursing Service:

The strength of nursing services is as under:-

	<u>Sanctioned</u>	<u>in Position</u>
Nursing Sisters	75	63
Staff Nurses	417	317
Student Nurses:	-	
General Nurses	-	41
Mid-wifery	-	12

Medical Education:

The hospital gives facilities for undergraduate teaching of A.I.I.M.S. A unit

each in surgery and medicine of the A.I.I.M.S.  
functions in the hospital.

Nursing Home Nil.

Drugs & Stores:

The total expenditure on drugs was  
app. Rs. 24 lakhs; out of which Rs. 4.63 lakhs  
was for the drugs in O.P.D.

Kitchen:

All patients are dieted.

The approximate cost of diet per patient  
is Rs. 1.75 per day.

Laundry:

The hospital is provided with mechanical  
laundry. There is, however, no mattress  
sterilizer and no arrangement exists for chemical  
disinfection of blankets.

No Dharamshala is provided for patients'  
relatives.

The Hospital has an Advisory Committee.

The general sanitation is under the charge  
of one Sanitary Inspector with a squad of  
12 sweepers.

Central Sterilization:

There is an organised Central Sterilization  
Department where equipment, linen, dressings  
etc. are sterilised by high pressure steam  
sterilization. Plastic equipment is sterilised  
by chemical sterilization.

Physio-therapy Deptt.

It has 6 physiotherapists. There is no prosthetic workshop.

Workshop

For repairing hospital equipment like trollies, steel chairs a small workshop is provided.

Maintenance Services:

The maintenance of the hospital building and allied services is with the C.P.W.D. Alternative arrangements for water and electricity in the event of a break-down exist.

Mortuary:

The number of post-mortems performed is small. Medicolegal post-mortems are carried out by the A.I.I.M.S. staff.

<u>Staff:</u>	<u>Full time</u>	<u>Hony.</u>	<u>CGHS.</u>
1. Medical including			
Specialist, General Duty			
Medical Officers, Specialist	48	-	10
Registrars & G.D.M.Os.	58	-	15
House Surgeons.			
Registrars	64	-	-
House			
Surgeons	110	-	-
Internees	10	-	-
2. Para-medical	742	-	7
3. Ancillary	1,105	-	21
4. Ministerial	109	-	5
5. Non-ministerial	21	-	-
	<u>2,267</u>	<u>-</u>	<u>58</u>

Unions -

The Hospital has a Union of para-medical staff.

Standing Orders:

The hospital has no standing orders.

Budget & Finance:

The total expenditure during 1966-67 was to the tune of Rs. 120 lakhs as under:-

Budget allocated during

	<u>1966-67</u>
a) Pay and allowances:	
i. Establishment	25,71,955
ii. Officers	8,57,304
iii. Allowances including those of officers	25,11,565
b) Stores & equipment )	
c) Medicine )	38,59,649
d) Other charges	22,53,132
	<hr/>
TOTAL:-	1,20,53,605
	<hr/>

Future Development Programme

The main schemes of construction are in respect of supporting services e.g. development of operation theatre facilities, nursing school and hostel, residential accommodation for staff. The additional beds asked for are for emergency and infectious diseases. Air conditioning of hospital is also proposed.

Plan programme is for Rs. 205.41 lakhs.

Some of the works are:

	<u>Rs. in lakhs</u>
Construction of operation theatres	17.31
Air conditioning of operation theatres	10.36
Nurses hostel	24.00
Staff quarters	30.00
Expansion of Central Institute of Orthopaedics	10.00
OPD with 100 emergency beds	20.00
Postgraduate school	6.00
V.D. Centre	4.00
Nursing School and Hostel	24.00
Infectious diseases block	10.00
Airconditioning of hospital	22.00

19. Observations:

Administration:

The hospital has only general wards. Patients, who desire to avail of nursing home facilities, are therefore unable to avail of the services of the specialists attached to this hospital.

The hospital has been for years in the process of conversion from old barracks to new multi-storeyed blocks. Old buildings exist side by side with modern ones.

The Orthopaedic Institute is in the same campus with 150 beds.

The Medical Superintendent is also Consultant in Surgery and Surgeon attached to the hospital. He is assisted by a Deputy Medical Superintendent and a Day Administrative Officer trained in hospital administration.

Information Centre:

Emergency and Accident service must have a central information office. The reception and enquiry counter is not functioning effectively as the O.P.D. <sup>the</sup> at ~~present~~ moment is dispersed in different departments.

General Sanitation:

In view of the fact that new construction is going on and building material is scattered all over the place, the sanitation is below par.

There is no incinerator for disposal of hospital waste.

Medical Store:

The annual expenditure on stores is about Rs. 38.00 lakhs. The method of accounting of issues and receipts of medicines requires improvement. Stock verification is being done but the records are not according to the standard procedure. None of the entries in the ledger are initialled. These are full of corrections and over-writings and in different inks.



The accommodation is insufficient. The original packings received are stocked as such and accepted as correct for stock verification.

Medical Records:

The Medical Record Library started in this hospital is very good.

Pharmacy:

The Pharmacy in the O.P.D. is not very clean. The records of issues and receipts are not on proper forms.

Kitchen & Diet:

Out of the three sanctioned posts of dieticians, only one is in position.

undry:

Break-down in the service occurs off and on. Side by side there is a Dhobi system on contract basis. Ironing of washed linen is done by dhobies.

Medical Services:

Out-patient Department:

There is no centralised O.P.D. in the hospital. Patients find it difficult to reach the appropriate O.P.D. due to lack of directions.

C.G.H.S.

The C.G.H.S. has its own separate referral out-patient department. The daily average attendance of hospital O.P.D. comes to about 2,000 cases (old and new). Waiting space is most inadequate. W.C. facilities in O.P.D. are insufficient.

A new centralised OPD is contemplated. In view

of the recommendations made elsewhere with regard to the integration of the AIIMS Hospital and Safdarjang Hospital, a joint programme of development may have to be considered.

In-patients:

There are two types of wards; old barracks and the newly constructed multi-storeyed blocks. All wards are over-crowded. There is no special ward accommodation. This is one of the priorities for the institution.

Paediatrics:

The micro-chemical laboratory attached to this unit is not functioning effectively because of lack of equipment and staff. No record of cross infection is maintained.

Psychiatry:

No beds are provided. Only outpatient treatment is available. It is very necessary that a hospital of this size should have a psychiatric ward of 20 beds. This, however, could be considered when the AIIMS Hospital and this hospital are integrated.

Cancer:

Patients requiring radio-therapy are kept in the Cancer unit. Mostly cases come at a late stage.

Surgical Services:

The load of general surgical work is heavy and the quality of surgical service is very good. But the new theatre block that has been planned is far away from the main building which will necessitate

Obstetrics & Gynaecology:

Out of about 5,000 live births last year, 636 were pre-mature. For the care of pre-mature babies 8-10 incubators with other accessories are maintained.

Plastic & Burns Unit:

There are 28 beds for plastic surgery and 36 in the burns unit. 3 beds are provided in the recovery room. This unit is very well run, but has to be further strengthened.

Institute of Orthopaedics:

The Institute of Orthopaedics is well organised and post-graduate training facilities exist.

The staffing pattern of the surgical division requires to be brought up to the standards for teaching institutions.

Operation Theatres:

The existing operation theatres are not suited for aseptic surgery.

Arrangement for continuous supply of cold and hot sterile water is not available in the existing theatres.

Bacteriological culture shows absence of cross-infection in the theatre. The culture tests are done for some items in the theatre. Water sterilizer is not yet installed. Boiled water from the utensil sterilizer is used.

In the new building 14 new theatres are provided. They are, however, away from the Central Supply Service.

Clinical Pathology Services:

The Registry of Pathology (ICMR) is located in the main laboratory and is supposed to look after the technical quality of the morbid anatomical service. The Indian Registry is supervising and is actively participating in the diagnostic histology laboratory. Very little supervision is done in any other laboratory

Haematology:

The quality of the work in the laboratory attached to the emergency ward is poor.

The out-patient laboratory, located in two small rooms, is run by 3 technicians with no supervision by trained medical personnel.

The main haematology laboratory consists of one laboratory technician, one assistant technician and one laboratory attendant. They prepare about 15-16 haemograms a day and occasionally one of the officers helps of the histology laboratory with bone marrow smears.

Haematological service of this hospital is grossly inadequate and needs to be strengthened both with trained medical officers and adequate numbers of technicians.

Bio-chemistry:

The bio-chemical work is being handled in laboratories set up in 3 different parts of the hospital. The main bio-chemical laboratory which handles CGHS work and the bulk of hospital work is located in the department and is under the

charge of a medical officer who is not a trained bio-chemist. The micro-method paediatric laboratory is under the charge of a qualified bio-chemist. The laboratory is inadequately equipped and poorly staffed.

The third bio-chemistry laboratory attached to cancer section has a lot of equipment. The accommodation is inadequate to operate these.

Laboratories is not up to the requisite standards.

The quality of work in all the three bio-chemical laboratories should be located in a central place and the resources pooled together under the charge of a well-trained qualified bio-chemist.

The Isotope Laboratory is under the control of an Army Officer and is doing good work.

Microbiology Laboratory is handicapped because of insufficient basic equipments like auto-claves and sterilisers which often go out of order. There is only one qualified Microbiologist. No emergency service is provided.

#### Radiology:

Diagnostic: The diagnostic department also attends to medico-legal cases. The effective manpower, is, however, correspondingly reduced because of attendance in the courts.

In the room where 1000 MA Unit is installed there is a constant seepage of water in the wall which is completely wet. This is extremely dangerous not only for the machine but also for those who work on it.

No proper records exist in the department.

Duplications of interesting cases are made and retained by the department. X-ray photographs are tagged to the individual medical records and destroyed after 5 years.

The staffing pattern of the radiology department is inadequate. As there are post-graduate students, it is necessary that there should be a professor and sufficient number of Assistant Professors for diagnostic radiology.

Radio-therapy: Working is quite satisfactory.

Blood-Bank:

The Blood Bank Department occupies one full floor of the laboratory building. Apart from dispensing blood, this section also undertakes preparation of intravenous infusions. This is the function of the Pharmacy Department and should be undertaken in collaboration with the Central Sterilization. Sterility maintained in this laboratory can be seriously questioned, since for many years the supplies like blood and intravenous fluids have not been subjected to adequate bacteriological examination. The over-all supervision of the quality control of this very essential hospital service is much below the expected standards. The organisation of a Central Blood Bank in the premises of the Safdarjang Hospital has been recommended separately.

Coordination: Collaboration with the AIIMS exists particularly in the departments of General Surgery and General Medicine dealt with elsewhere in the report.

Education & Training:

This institution is giving facilities for

which needs to be further strengthened. The entire under-graduate load of the AIIMS Hospital could be transferred to this institution.

There is also training of post-graduates for M.S., M.D., D.A., and other qualifications of the Delhi University in this institution. However, the supporting services for this purpose are inadequate and require to be augmented.

Continuation education is also given in this institution for CHS Medical Officers, which has to be further developed.

Future Development:

The future development programme of this institution should be carefully examined in the light of the recommendations of integration of the AIIMS and this hospital. Total integration of the two institutions has been recommended in the interests of education, economy, efficiency, patient care and research and to organise a referral system of service to the patients in Delhi.

The staff of this hospital should be augmented to meet the requirements of the post-graduate trainees as well as the patients' service.

ALL INDIA INSTITUTE OF MEDICAL  
SCIENCE HOSPITAL, NEW DELHI.

20. Basic Data :

This hospital has 560 beds including 26  
paying ward beds. All the distribution of beds under  
the different specialities is as under:-

<u>Details of Specialities</u>	<u>No. of beds</u>	<u>No. of units/ teams for each special- ity</u>	<u>Composition of the Unit.</u>
Medicine	37	2	
Cardiology	35	2	
Endocrine & Metabolic	20	1	Each Unit is composed of Pro-
Neurology	15	1	fessor/Associate Professor Asstt.
Surgery	42	2	Professor Regist-
Orthopaedics	36	2	rars, Clinical
Thoracic Surgery	21	2	Residents (postgraduates)
Neuro-surgery	12	1	1 House Officer and interns.
Urology	17	1	
Paediatrics	72	2	
Eye	40	3	
E.N.T.	16	1	
Obstetrics	30	2	
Gynaecology	28	2	
Skin	24	1	
Psychiatry	12	1	
Radiotherapy	4	1	



Common Pool BedsNo. of beds

The distribution is as under:-

Private wards	26	All aforesaid units utilise these beds.
Staff beds	10	
Casualty & Emergency	30	
Isolation	2	
Intensive Therapy Unit	4	
Post-operative ward	17	
Total:	560	

During the year 1966, 9854 patients were admitted.

Out-patient services are provided in the under-mentioned specialities:-

<u>Medical Disciplines</u>	<u>Attendance during year</u>			<u>Staff posted</u>
	New	Old	Total	*Medical *Para-medical
General Medicine	29090	20303	49393	*The composition of a unit on a given day is Professor/ Associate Professor, Assistant Prof. Registrars, Clinical Residents (post-graduates) House Officers.  **Nurse, Medico-social worker, Dietician, Technician, Physiotherapist, Nursing Orderly, House-keeping staff as and when necessary.
Chest	629	1828	2457	
Cardiology	1955	3982	5937	
Gastro-enterology	939	1252	2191	
Endocrinology	1263	3688	4951	
Neurology	1944	2238	4182	
Epilepsy	781	1728	2509	
Vertigo	87	55	142	
<u>Surgical Disciplines</u>				
General Surgery	11735	9976	21711	
Orthopaedics	11445	16012	27457	
Urology	521	763	1284	
Proctology	437	476	913	
Polio	129	197	326	

	New cases	Old cases	Total
Neuro-surgery	628	691	1319
<u>Paediatrics</u>			
General Paediatrics	9825	12758	22583
Well Baby	558	888	1441
Follow-up	203	835	1038
<u>Ophthalmology</u>			
General Ophthalmology	17126	17045	34171
Squint & Epileptic	263	264	527
Eye Bank	403	354	757
Glaucoma	328	399	725
Uveitis	94	191	285
Med. Ophthalmology	672	367	1039
Detachment of Retina	99	101	200
Korato-Plasty	200	131	331
<u>Otolaryngology</u>			
General Otolaryngology	11832	15,783	27,615
Audiometry & Speech	273	197	470
<u>Gynaecology &amp; Obstetrics</u>			
Gynaecology	1673	5257	11430
Post-natal Clinic	162	66	228
Sterility	839	1281	2120
Family Planning	1565	2235	3800
Ante-Natal Clinic	1212	3043	4255
<u>Dermatology</u>			
Dermatology	9717	8256	17973
Tumour Clinic	89	112	201
Allergy Clinic	338	627	965
Pigmentary	524	1105	1620

	<u>New cases</u>	<u>Old cases</u>	<u>Total</u>
<u>Psychiatry</u>			
Psychiatry	3276	13338	16614
Child Guidance	419	376	795
Marriage Counsel	212	614	825
Dental	7134	8028	15162
E.H.S.	8042	23552	34594
Casualty	12956	62	13018
	<hr/>	<hr/>	<hr/>
Total:	156235	183726	339961
	<hr/>	<hr/>	<hr/>

The Laboratory Service:

The work-load in this department and the staff posted are as under:-

Diagnostic Facilities:	<u>Average daily workload</u>		<u>Staff posted</u>
	<u>Out-patients</u>	<u>In-patients</u>	<u>Para-Medical</u>
(i) Clinical	130	5	1
(Urine, stool and other body fluids for routine examinations)			
(ii) Haematological	*200 specimens for different haematological investigations.	30	1
(iii) Biochemical	*50 specimens		
(iv) Bacteriological			
(v) Histopathological			
(vi) Serological	*15		

\*All these specimens are drawn collected and despatched to different units by clinical pathology lab.

Radilogy- Diagnostic

The diagnostic departments have 12 units with a range of 30 M.A. to 1000 M.A. During the year 1966, 59,468 X-ray examinations were done i.e. a daily average of 225. The staff employed consists of 8 medical officers and 19 para-medical staff.

Radio-therapy:- Superficial and deep X-ray and cobalt treatment are available.

Short wave and diathermy are provided in the physio-therapy unit.

Operation theatres:- The hospital has 9 operation theatres. The linen and dressings are sterilized in the central sterilizing room.

Maternity services: 30 beds are provided with 4 air-conditioned labour rooms.

Emergency and accident services: Round the clock service is provided with 6 beds attached to the Department for observation and resuscitation. In addition, there is a 30 bedded casualty ward to which patients from the casualty department are transferred.

Ambulance service: The A.I.I.M.S. hospital is not in the emergency '102' pool. The hospital ambulances are exclusively used for transportation of cases within the campus.

Blood Bank: During the previous year 3,879 units of blood were collected out of which 80% were from professional donors.

Medical Audit: For maternal death, there is a medical audit committee of the hospital which meets within a week of every maternal death.

Clinico-pathological conferences are held which help in the evaluation of professional work.

Nursing service: The hospital has 216 fully trained nurses. There is no provision for training of student nurses.

Medical Education: The hospital is a part of the post-graduate Institute which is a residential university. Under-graduate teaching facilities are also available.

Nursing Home: It has only 26 paying beds.

Drugs and Stores: The total expenditure on drugs is about Rs. 10 lakhs.

Kitchen: The food served is approximately of 2600 to 2800 calories. The average cost is Rs. 2 per day per patient.

Laundry: A mechanical steam laundry is installed in the hospital.

Welfare: The hospital has no Advisory Committee. There is no 'Dharamsala' for the patient's relatives.

Central Sterilization: The Central Sterilization and Supply department undertakes sterilization of instruments, dressings, syringes etc.

Blankets and mattresses are sterilized by steam laundry.

Physio-therapy: 6 Physio-therapists are in the

Workshop: The hospital has a well developed workshop to undertake repairs of medical and electronic equipments and other equipments like trolleys, wheel chairs, air-conditioners, refrigerators etc.

Maintenance service: The maintenance service of the hospital is done by the A.I.I.M.S. staff who work under the administrative control of the Superintending Engineer.

Mortuary: 275 post-mortems were done during the year 1966 including medico-legal ones.

Staff: All the staff of the Institute are full-time. It comprises of :

			<u>Full-time</u>	<u>Honorary</u>
				Nil
1. Medical including specialist, general duty M.Os., Registrars and House Surgeons.	Specialists - 63 G.D.M.Os - nil Registrars - 62 House Surgeons - 56		All staff is full-time.	None is borne on the strength of C.G.H.S.
2. Para-medical	-108			
3. Ancillary	-425			
4. Ministerial LDC 33, UDC 4, H.C. 1				
5. Nurses	-201			

There are 5 staff unions and none of them is recognized by the Institute.

Standing order: The hospital has standing orders.

#### Budget and Finance

Total budget during the year 1966-67\*

(Rs. in lakhs)

a) Pay and Allowances

1) Establishment 26.67

11) Officers 1.69

b) Stores & Equipment 2.50

c) Medicines (and Dressings) 10.10

d) Other Charges 10.24  
(diet, Stationery, Laundry,  
Film badge service,  
barber, General Stores  
and E.H.S. )

e) Bed strength - 569

f) Bed occupancy - 85% - 90%

g) Source of income if any, 3.25  
other than paid by the  
Government.

h) Details of proposals - Proposals are submitted  
submitted during the to Finance Committee  
last three years for and generally suggestions  
affecting improvement have been agreed to.  
in the hospital servi- However, due to  
ces which may not have difficult of Finances,  
been sanctioned for certain proposals for  
want of financial re- improvements cannot  
sources. be accepted and have  
to be postponed.

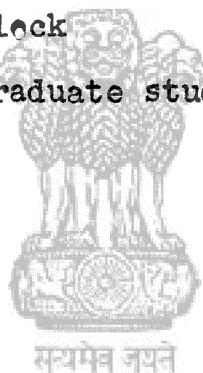
\*This does not include the salaries of Lecturers,  
Research Assistant, Assistant Professors, Professors  
and Stipends of Clinical Residents but includes  
salaries of House Officers and Registrars.

Future Developments:

The schemes envisaged are connected mainly with  
the teaching side of the Institute and additional  
residential accommodation for staff and students.

Total outlay is for Rs. 354 lakhs.

Spill over of works:	93.00
New works	
Residential quarters	177.00
Students hostel (already near completion)	8.65
Reconditioning of post-graduate and teaching blocks	15.00
Central Store Department	1.50
Engineering Stores	1.05
Dental College	23.95
Administrative block	9.69
Hostel for postgraduate students	6.54





21. OBSERVATIONS:

Administration:

The All-India Institute of Medical Sciences, the premier institute of India, has been developed during these eventful years, with international assistance. The hospital facilities were given by the Safdarjang Hospital in the earlier years. Later on improvised accommodation for the hospital was made available in the Nursing College building. The new buildings for the hospital are nearing completion and it is stated that some of the departments are in the process of shifting. The hospital facilities in this institution so far have been developed with inevitable handicaps.

The Institute at present has no full-time Medical Superintendent. The Professor of Anaesthesiology is officiating in this appointment in addition to his own duties.

Medical Records:

In this institution, the hospital medical record service is not adequate. A well-organised hospital record library is very essential for patient care evaluation, research and publications. Further, as this Institute conducts a post-graduate course in hospital administration, a well developed hospital records section is an inescapable necessity.

Nursing Administration:

The status of Nursing Superintendent should be raised to have better control over nursing care.

At present the Institute does not have a nursing training programme.

Communications:

The hospital does not have any paging system.

Standing Orders:

The Hospital has no standing orders.

Physical facilities are good and when the whole hospital shifts to the new premises, it will afford excellent opportunities for a higher standard of medical and surgical care.

Work-shop

There is a good workshop with great possibilities for training of Technicians from other centres in the country. This should serve as a regional workshop for institutions in Delhi.

Staff:

The hospital organisation is divided into various specialities, disciplines and units. It is stated that at present the heads of units and divisions function independently. It is necessary to have Heads of Departments to coordinate the activities of the various divisions in the interest of efficiency of service.

Laboratory services:

The Departments of Pathology, Microbiology and Bio-chemistry of the Institute are well equipped and undertake both undergraduate and postgraduate training. They carry out both fundamental and applied research of a high standard.

However the role of these departments in organising the clinical pathology service in the hospital has so far been ineffective.

The clinical biochemistry investigations are being undertaken by the department of pathology which is considered unsatisfactory. The committee was informed that these services were being transferred to the Biochemistry Department which is a step in the right direction.

The organisation of the central collection room, the out-patients' laboratory and the emergency laboratory service of the hospital should be reorganised on the lines recommended under the general recommendations.

Radiological Department:

Radio-diagnostic: This is a good service with adequate provision for filing and recording of the x-ray photographs. The Department is well organized and is under an Associate Professor and has adequate staff and equipment.

The Department of Radio-therapy is under the Professor and is adequate both in regard

to staff and equipment. However, it has been suggested in general recommendations that it will be in the interests of both the Institute and the Safdarjang Hospital that their Radio-therapy units are integrated with provision for adequate number of indoor beds for therapy.

Medical Service:

Out-patients: The Out-patients Department is one of the best in the country and if a referral system is adopted, greater service can be rendered to larger numbers of those who really need such service. In the out-patient department there is a need for additional social workers and sign boards.

Surgical Service:

The standard of surgical service is good. However, the available clinical material is not sufficient at present. The operation theatres are housed in the nurses' lecture hall which is divided by half partitions into cubicles. This is an unsatisfactory arrangement. The new operation theatres are understood to be ready for occupation. The Committee, however, considers that even the number of theatres in the new block will not be enough for the various specialities and to provide separate theatres for septic and emergency cases. This consideration also calls for integration of the two hospitals.

There should be a post-operative ward, an intensive care unit and a coronary care unit in this complex.

Specialist care:

As mentioned above, there is need for developing specialist care in this institution in various specialities which are not otherwise available elsewhere. The institution is fortunate in having rare and modern equipments not available in other hospitals.

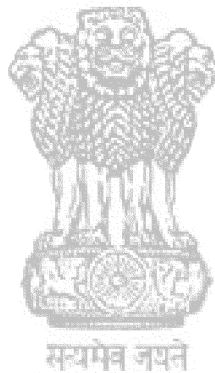
Co-ordination:

The bed strength in the improvised hospital is 560. The new buildings can accommodate 750, including 60 special ward beds. With the development of a large number of specialities, it is unlikely that there will be enough beds to give appropriate training facilities for the post-graduates. It has also been noted that the Rajendra Prasad Ophthalmic Centre is making a provision of hospital facilities up to 300 beds. The advisability of developing so many beds in one discipline requires further thought. If the Institute hospital concentrates on the development of specialities, the general surgical and medical care can be organised in the Safdarjang Hospital.

Here it is necessary to point out that the integration of the Safdarjang Hospital and the All-India Institute of Medical Sciences hospital is a vital necessity if a referral system is to be developed for all the hospitals in Delhi at the All-India Institute of Medical Sciences hospital. This requires, therefore, reorganization of the Safdarjang Hospital and the Institute hospital so

That certain disciplines like plastic surgery, cancer, paediatrics, obstetrics and gynaecology and orthopaedics, which are already well-developed at the Safdarjang Hospital, could be utilised.

It is, therefore, recommended that the integration of these two institutions i.e. the A.I.I.M.S. and the Safdarjang Hospital should be taken up immediately by an appropriate committee as has been recommended elsewhere.



Lady Hardinge Medical College and Hospital  
and Kalavati Saran Children's Hospital.

22. Basic Data: This hospital has 567 beds and  
228 childrens beds provided in the Kalavati Saran  
Children's Hospital.

The specialities provided are-

<u>Name of the speciality</u>	<u>No. of beds</u>	<u>No. of Units/Teams for each special-ity</u>	<u>Composition of the Unit</u>
Surgery	114 (L.H.M.C.&.H) 36 (K.S.C.H.)	4 Units- (a) Units for Gen. Sur. (Burns Unit) (b) Unit for Urology and Gastroenter-logy. (c) Unit for Ortho paedics (d) Unit for Paedia-tries (e) Casualty Deptt.	Each Unit consists of 1 Prof. of Head of Deptt. 1 Reader 1 Lecturer 1 Registrar 2 House Surgeons
Medicine	90	3 units	Each unit consists of- 1 Reader or Lecturer 2 Registrar 2-3 House Surgeons.
Orthopaedics	Comes under the Deptt. of Surgery.		
Eye	26	1 unit	1 Reader 1 Lecturer 1 Registrar 2 House Surgeons.
E.N.T.	27	1 unit	1 Reader 2 Registrar 1 House Surgeons.
Dermatology Venereology	No special bed treated in Surgical ward.	1 unit	1 Lecturer 1 Registrar 1 Social Worker
Gynaecology & Obstetrics	226	4 units: A, B, C, & D.	<u>Unit 'A'</u> 1 Professor 1 Lecturer 1 Demonstrator 1 Registrar 6 House-Surgeons  <u>Unit 'B'</u> 1 Professor 1 Lecturer 1 Registrar 5 House Surgeons.

Gynaecology &  
Obstetrics

Unit 'C'  
1 Reader  
1 Lecturer  
1 Registrar  
3 House-Surgeons.

Unit 'D'  
1 Reader  
1 Demonstrator  
1 Registrar  
3 House-Surgeons.

Paediatrics 228 including  
(Kalavati Saran beds for Phys.  
Children's Med. & Rehab.  
Hospital)

6 Units  
1 Surgical (in  
the Deptt. of  
L.H. Medical  
College &  
Hospital)  
1 Neonatal  
1 Non-  
infectious  
1 Neurology  
1 Gastro-  
intestinal  
1 Respiratory

All the Units are  
supervised by  
1 Professor  
3 Readers (2  
posts vacant)  
3 Lecturers  
15 Registrars (3 for  
Casualty)  
12 House-Surgeons.

There are 36 paying beds.

During the year 14,974 patients were admitted.

In addition, 5,551 new borns were registered.

Out-patient services are provided in the under-  
mentioned specialities:-

<u>Speciality</u>	<u>Attendance</u>			<u>Total in the year</u>	<u>Staff posted</u>	
	<u>New</u>	<u>Old</u>	<u>Total</u>		<u>Medical</u>	<u>Para- medical</u>
Gynae.	28913	16130	54043	Grand Total of New and Old cases 161606	Senior Doctors, Registrar's House-Sur- geons Interns, & Medical students.	Nurses, Clerks, Ayahs & Sweepers
Ante-natal	18873	9141	18014			
Medical	11184	17627	28811			
Surgical)						
Dental }	16787	15614	32401			
V.D. }						
E.N.T.	6681	6438	13119			
Eye	5237	8981	14218			

Daily attendance about 500 (old & new)

Kalavati Saran Hospital data not included.



### Laboratory services

Work load in this department and the staff posted are as under:

<u>Laboratory</u>	<u>Average daily work load</u>		<u>Staff posted</u>	
	<u>Out-patients</u>	<u>In-patients</u>	<u>Medical</u>	<u>Para-medical</u>
i) Clinical	The Labs. do not keep record for in or out-patients investigations.		1 C.Path. 1 Demonst.	1 Technician 1 Lab. Asstt.
ii) Haematological	27.9 investigation			
iii) Bio-chemical	55.8		2 Demonst.	1 Technician 1 Lab. Asstt.
iv) Bacteriological & Parasitology	112.2		2 Demonst.	1 Lab. Asstt. (K.S.C.H.)
v) Histopathological	29.5		1 Reader 1 Lecturer 2 Demonst.	1 Technician 1 Lab. Asstt.

### Radiology

The diagnostic department has 7 units. All of these are old. Approximately 11,000 films, are exposed annually giving a daily average of 45 to 50 films.

The staff consists of one professor, 1 reader, 1 registrar, 1 physicist, 3 technicians, 1 dark room assistant and 1 staff nurse.

### Radio-therapy

Short-wave and diathermy treatment is done in the Kalavati Saran Children's Hospital (Department of Physical Medicine).

The Deep X-ray Therapy Unit of 250 K.V. and Cobalt needles for surgical use and cobalt tubes for Gynaecological use are available.

### Operation Theatres

The hospital has 4 operation theatres- one each for surgical, gynaecology and obstetrics ENT and Casualty work.

There is a recovery room with 3 beds attached to the theatre.

### Maternity service.

266 beds are provided in this Department.

### Emergency and accident service

24 hours casualty service is available and is connected with "102" Call. One ward of 6 beds is attached to the department. After OPD hours, all admissions are routed through the casualty.

### Ambulance service

One van is available and two are being got ready.

### Blood Bank

There is no Blood Bank Officer. The Professor of Pathology is in overall charge. The bank functions only from 9 A.M. to 4 P.M. The blood is tested for RH but Rh negative blood is not stored.

Medical audit: A Medical Audit Committee has recently been established. It meets once in 3 months.

Nursing service: Of a total of 340 nurses, 120 are fully trained and 220 student nurses.

### Medical Education

The hospital is an integral part of the Medical College providing both under-graduate and post-graduate training.

### Nursing Home.

The total number of beds is 36. These are cottages, mostly of maternity cases.

### Drugs and Stores.

The total expenditure on drugs and stores was, during 1966-67, a little over Rs.3.22 lakhs.

### Kitchen

The daily average cost of food is Rs.1.16 per patient.

### Laundry

Dhobis are employed for washing.

### Welfare

There is no provision for Dharamsala. There is no library for the patients. The hospital does not have an Advisory Committee.

### Central Sterilization

Sterilisation is done only in the operation theatre.

### Physio-therapy.

This Department is located in the Kalavati Saran Children's Hospital with 5 Physio-therapists.

### Workshop.

There are no facilities.

Maintenance services are with the P.W.D.

### Mortuary

Only 34 post-mortems were done during the

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## Staff

	<u>Fulltime</u>	<u>Honorary</u>
1) Medical including	Specialist 61	-
Specialists General	G.D.M.Os. 1	-
Duty M.Os., Registrars	Registrars 30	-
& House-Surgeons.	House Surgeons 52	-
2) Para-medical	70	-
3) Ancillary	463	-
4) Ministerial	51	-

## Unions

Para-medical staff has two separate unions for the technical and non-technical staff.

## Standing orders.

The hospital has no standing orders.

## Budget and Finance

Total Budget	-	Rs.60,80,000
Total Estt. charges	-	Rs.38,89,000
Other charges	-	
Stores & equipment	-	Rs.21,91,000
Food	-	Rs. 1,80,000
Medicines	-	Rs. 3,50,000
Equipment	-	Rs. 3,00,000

## Future Development Programme

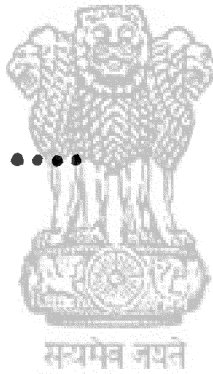
The proposed programme is to make good the deficiency of accommodation and equipment in supporting services, and residential accommodation for staff.

Total outlay for construction is Rs.150 lakhs.

### Main items are:

	<u>Rs. in lakhs.</u>
Hostel for registrars and House staff	6.31

ENT with operation theatres	8.59
Laundry	1.00
Airconditioning of mortuary	2.20
Hospital administration Block	11.60
X-ray Block	4.18
Operation theatres	15.00
Residential quarters for staff	13.76
Residential quarters (III phase)	40.54
Equipment	21.73



### 23. Observations

The Lady Hardinge Medical College and Hospital is exclusively meant for women and children. 40% of the beds are reserved for obstetrics and gynaecology.

The Kalavati Saran Children's Hospital located within the premises of the Lady Hardinge Hospital is an exclusively children's hospital. Both hospitals function as a single unit.

The Medical Superintendent is also the Principal and the Professor of Surgery. She is assisted in administration by the Deputy Medical Superintendent, the Nursing Superintendent and the Administrative Officer. There is no separate Stores Officer or Accounts Officer.

The Nursing Superintendent is responsible for general nursing administration and the nurses training school.

#### Medical Records:

No proper records are maintained either for out-patients or in-patients.

#### Sanitation:

The general sanitation of the buildings, wards, departments and the surroundings is very poor.

There is no incinerator. All hospital refuse is thrown into the public refuse bins outside the hospital.

A portion of the hospital compound is occupied by unauthorised hutments dwellers. This

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Further adds to the insanitary condition of the hospital.

Kitchen:

Coal is used for cooking. No proper records are maintained of the health status of the persons working in the kitchen. The mode of cooking is antiquated and unhygienic. There are no arrangements for cold storage. Food is taken to the wards in tiffin carriers.

Laundry service:

There is no mechanical laundry. Washing is done by dhobies. Linen is dirty and the change is infrequent.

Pharmacy:

The general sanitation is not adequate. There are no arrangements for weighing the ingredients for preparation of mixtures. Intravenous infusions are prepared in the pharmacy but there is no proper method of testing whether the solutions are pyrogen free or not.

Discipline:

There are two unions of Class IV servants having bad relations with each other and with the authorities.

Lift service:

The only lift in the hospital remains out of order and the patients are carried on stretcher manually.

Public Relations:

There is need for improving the public

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relations by having a good information centre in the emergency department.

Physical facilities:

Additional buildings are necessary for improving the efficiency of the hospital and to provide adequate accommodation for the patients. There is need for a surgical block and new operation theatres.

Staffing pattern also needs augmentation according to the requirements of patient care and the standards laid down by the Medical Council of India. The Committee was informed that a Review Body is seized with the problem and would make necessary recommendations. The equipment of the hospital is out-dated and requires immediate attention. The institution should be modernized to serve as a really model centre for the education of women in medical sciences.

Laboratory services

While the college departments of Morbid Anatomy, Biochemistry, Haematology and Microbiology are well provided both with regard to staff and equipments, the clinical pathology service of the hospital needs total reorganization. The overall supervision of the College Departments on the laboratory units working in the hospital is inadequate and ineffective. The laboratories do not undertake any emergency work after 5.00 P.M. except in the Kalavati Saran Children's Hospital. The Biochemistry service of the hospital is



unsatisfactory and is at present under the Department of Biochemistry with meagre technical help. The equipment in this laboratory is both inadequate and out-dated.

#### Radiology:

The diagnostic Radiology Department does not offer any emergency service after 6.00 P.M. The technical staff, both medical and para-medical, is inadequate for the work-load. The equipment available to this Department is inadequate and needs replacement.

There is no separate Radio-therapy Department and the work undertaken under this discipline requires strengthening so as to play an effective role in the teaching hospital. The radio-therapy needs complete reorganisation so that it is able to deal with cancer cases in women.

#### Blood Bank.

The Hospital does not have regular blood bank service and the majority of the transfusions are done by blood obtained from private sources.

#### Out-patient Department:

The out-patient department is crowded and requires further expansion.

#### In-patients

The wards are overcrowded and patients are put on the floors. This is particularly so in the Department of Obstetrics and Gynaecology.

The linen in the ward was not enough for the number of patients, so much so that the general hygiene is extremely unsatisfactory.

The Committee noted with satisfaction that very good research work is being done in the Cardiology Department of the Medical Division.

Surgical service:

The operation theatres are ill-equipped and have none of the modern equipments which are absolutely necessary.

There is no central suction or central supply of gases. The Anaesthesiology Department has no respirator and since it is a teaching institution for post-graduates, the Anaesthesiology Department has to be strengthened with the appointment of a Professor.

Central Sterile Supply Department:

There is no Central Sterilization Department and most of the instruments and syringes are sterilized by boiling in the respective wards.

Obstetrics:

Rate of infection is fairly high in the Department of Obstetrics and Gynaecology. The still birth rate is 60 per thousand.

Maternity cases are followed up within a radius of 2 miles.

There is no separate ward for the treatment of cancer.

There is no separate unit of Orthopaedics.

### Education and Training:

The Lady Hardinge Medical College and Hospital do not have the full facilities required for medical education. 40% of the 567 beds are for obstetrics and gynaecology. The authorities have, therefore, decided that Willingdon Hospital should be an associate teaching centre for the Lady Hardinge Medical College. The co-ordination between these two institutions so far has been satisfactory up to a point but greater collaboration by utilizing the full facilities of the Willingdon Hospital is needed. This can only happen if all the appointments at the Willingdon Hospital are converted into teaching posts so that the entire hospital, excluding the nursing home, becomes a clinical centre for the Lady Hardinge Medical College. It is stated that action in regard to this is already pending with the Director General of Health Services/ Ministry of Health, Family Planning & Urban Development.

This is the oldest institution of its kind which should be developed into a national institute for women in medical sciences. The Committee notes with regret that the auditorium and library, for which sanctions have been given and for which the then President of the Union of India laid the foundation stone are still in the same stage as they were at the time of laying the foundation stone in 1960.

Emergency and casualty:

Only minor work is handled. The supporting x-ray and laboratory services are not available.

Kalavati Saran Children's Hospital

24. The mortality rate in gastro-intestinal diseases is about 25-30%, the main reason for high mortality being that diarrhoea cases are brought to the hospital at a very late stage.

The out-patient department is too small to meet the requirements. The hospital staff finds no time to devote to health education. Arrangement for treatment of tuberculosis cases is not satisfactory. The hospital has a central sterilization unit but no blood bank facilities. The laboratory undertakes routine clinical examinations. The Biochemical laboratory is run by Russian Technicians.

The staff sanctioned consists of one professor, three readers, three lecturers, fifteen registrars and twelve house surgeons. Of these two posts of readers are vacant.

The hospital should develop into a full-fledged Institute of Paediatrics and child health and full facilities for promotional, preventive, curative and rehabilitation services should be developed. This will give greater encouragement for research in the field of child

health where there is a great need for such studies. It may be noted that 40% of the population in India are under the age of 14 and the general mortality rate amongst children up to the age of 14 is about 50% of the total mortality. This is a matter of great importance in view of the family planning measures that are being taken so that every child that is born is preserved and conserved in the interest of national health.

With Russian collaboration, the Department of Physical Medicine and Rehabilitation is well developed. There is also a Psychiatrist attached to this department. In view of the importance of social paediatrics, greater emphasis is to be laid on this subject. This Department should also function in collaboration with the Social Obstetrics Department of the Lady Hardinge Medical College.

The staffing pattern of this Institution requires further scrutiny as there is only one fully qualified chief for such a large number of patients. The Review Body of the Lady Hardinge Medical College is stated to be seized with this situation also.

### Irwin Hospital

#### 25. Basic Data

The Irwin Hospital has a sanctioned bed strength of 1068. These are provided in 26 wards. The hospital has no nursing home facilities. The specialities are distributed as follows:-

<u>Details of specialities</u>	<u>No. of beds</u>	<u>No. of Units/ Teams for each speciality.</u>	<u>Composition of the Unit.</u>
Surgery	292	7	Head of the Unit (Prof. or Sr. Hony. Consultant).
Medical	258 (including 8 beds of tetanus)	7	
Orthopaedic	132	3	
Eye	67	3	
ENT	37	2	Reader Lecturer
Dermatology	16	2	Registrar
Gynea. & Obst.	137	3	
Paediatrics	73	3	House Staff
Dental	Beds utilised as and when required.		
Emergency Ward	40		

The total number of patients admitted during the year 1966 were 42,736.

#### Out-patients

Out-patient services are provided in the undermentioned specialities:-

<u>Speciality</u>	<u>Attendance</u>		
	<u>New</u>	<u>Old</u>	<u>Total</u>
Medical	65,545	79,705	1,45,250
Surgical	23,526	45,794	79,320
Paediatrics	27,640	41,795	69,435
Dental	17,516	11,037	28,553
V.D.	3,066	4,857	7,923
Skin	24,841	29,389	54,230
Eye	25,343	21,133	46,474
ENT	24,645	20,362	45,007
Orthopaedics	22,728	46,774	69,502
Gynae. & Obst.	19,602	20,677	40,279
E.S.I.	10,075	10,967	21,042
J.S.S./S.S. (for Government servants)	9,738	7,085	16,823
Casualty	69,220	-	69,220
Spl. Clinic	19,196	33,325	52,521
<b>Grand Total:</b>	<b>372,681</b>	<b>372,900</b>	<b>745,581</b>

i.e. about 2500 attendances (old & new) per day.

### Laboratory Services

The work load in this Department and the staff posted are as follows:

#### Diagnostic facilities

<u>Laboratory</u>	<u>Average daily work load</u>		<u>Staff posted</u>	
	<u>Out-patients</u>	<u>In-patient</u>	<u>Medical</u>	<u>Para-Medical</u>
i) Clinical	123	60	3	10
ii) Haematological	121	57		
iii) Biochemical	Not available			

iv) Bacteriological	9	66	7	12
v) Serological	19	19		
vi) Histopathological	Not available.			

#### Radiology.

This Department has 8 major units ranging from 200 M.A. to 1000 M.A. and 11 minor units in the range of 10 M.A. to 30 M.A. On an average 400 patients are x-rayed daily. Special investigations are done on an average for 30 patients a day.

The Medical staff consists of a Professor of Radiol-ogy, 1 Associate Professor of Radiology, 3 Lecturers and 6 Assistant Surgeons. The para-medical staff has 1 physicist, 1 technical assistant 23 radiographers, 1 dark room assistant and 1 x-ray machanic.

#### Radio-Therapy

Deep x-ray therapy, Cobalt 60 and cobalt tubes are provided. For electro-therapy, diathermy, ultra-violet and infra red lamps are available.

#### Operation theatres

In all there are 7 theatres for general surgery and orthopaedics.

No proper theatre is available for eye surgery for which temporary arrangements have been made in the O.P.D.

#### Central Sterilisation

Central sterilisation as such does not exist. Sterilisation of instruments is done by boiling.



Linen for theatres and dressings are autoclaved centrally.

#### Maternity

82 beds are provided in the obstetrics section, 55 for clean and 27 for septic cases. For gynaecology work 55 beds are sanctioned. There are 3 clean and 2 septic labour rooms.

#### Emergency & Accident service

Round the clock service is provided. 40 beds are attached to this Department. A post-graduate qualified registrar is in charge of the casualty. Senior specialist is available on call.

#### Ambulance Service

The hospital has only one ambulance in working order.

#### Blood Bank

During the year over 4500 units (350 ml.) of blood were collected. About two-thirds were professional donors.

#### Medical Audit

A medical audit committee exists, but has not met for a number of years.

#### Nursing service

347 fully trained nurses are in position. Of these 253 are staff nurses; the rest are Nursing Superintendent, Ward sisters and other administrative the rolls.

#### Drugs & Stores

Medicines worth Rs. 9 lakhs were purchased

during the year.

### Kitchen

The diet served is of 2700 calories. The cost perpatient per day comes to Rs. 1.40.

### Laundry

The mechanical laundry was commissioned in April, 1967 and is being put to limited use of rht eoperation theatre linen, washing about 9000 pieces a day. Dhobi system is continuing side by side.

### Patients' welfare

There is a hospital advisory Committee. The hospital has a Dharamsala for patient's relatives.

### Workshop

Arrangements exist but are inadequate and unsatisfactory.

Maintenance service is through P.W.D.

### Mortuary

About 300 medico-legal post-mortems were conducted during the year.

### Physio-therapy

3 physio-therapists attend to the patients.

### Staff

The Hospital has full time staff borne on the rolls of the Maulana Azad Medical College and the hospital itself. In addition 37 honorary specialists and 8 voluntary medical officers are

P.T.O.

attached to this hospital. The staff comprises of:-

<u>Staff</u>	<u>Full-time</u>	<u>Honorary</u>
Medical including	Specialists 10	37
specialist General	G.D.M.Os. I 17	
Duty M.Os. Registrars	G.D.M.Os. II 9	
& House Surgeons.	Registrars 37	
	House Surgeons. 84	

Voluntary Medical Officers - 8

Para-medical	Staff Nurses etc.	347
	Student Nurses	260
		<hr/> 607 <hr/>
Ancillary	Class III	140
	Class IV	859
		<hr/> 999 <hr/>
Ministerial		103

#### Union

There is no recognised union in the hospital.

#### Budget & Finance

Total budget	-	Rs.88,88,800
Total Estt. charges	-	Rs.42,06,500
Estt. charges & stores:		
Equipment	-	Rs.46,82,300
Food	-	Rs. 6,08,900
Medicines	-	Rs.23,85,700
X-ray	-	Rs. 3,79,600
Furniture	-	Rs. 85,000

P.T.O.

### Future Development Programme

The proposed schemes for the hospital are for improving in-patient and out-patient accommodation and for increasing specialised units.

Budget provision required is about Rs. 157 lakhs.

Plans are for construction of additional 450 beds to relieve the existing over-crowding and provide separate accommodation for emergency service.

	<u>Rs. in lakhs</u>
Burns and Plastic Unit	20.00
Radiotherapy Unit	20.00
Additional 100 beds for	
Paediatrics	27.00
Accident and Emergency	
Service complete by itself.	17.00
Operation theatre block	13.00
O.P.D. block	18.00
Central Sterilization service	
Residential accommodation.	37.50

P.T.O.

26.

OBSERVATIONS:Administration:

The hospital has a full-time medical Superintendent who functions under the over-all control and guidance of the principal Director of the Maulana Azad Medical College.

The Maulana Azad Medical College, the Irwin Hospital and the G.B. Pant Hospital should function as one complex with one chief for the entire organization. The Principal of the Medical College should also be the Director of Hospitals and should be in complete charge of all the three institutions. The Superintendents of the Irwin Hospital and the G.B. Pant Hospital should be subordinate to the Principal/ Director, without which it will be impossible to serve the cause of service to the patients, education and research.

There is a need for organizing a round the clock Central Reception and Enquiry for both hospitals in the Emergency and Casualty of the outpatients.

This hospital has honoraries as Junior and Senior Specialists in the clinical departments. The staff of the Maulana Azad Medical College also have clinical responsibilities.

Pharmacy:

There is a sub-store of the medical store attached to the out-patient pharmacy. It does not serve any useful purpose. Pharmacists

are employed in the out-patients for registration work. No account of any sort is maintained in the main dispensary.

Medical Record Library:

It needs additional space, equipment and personnel.

Kitchen:

Health record of cooks and others working in the kitchen is maintained in a register. The last examination was carried out a year and a half back and two or three cooks appear to have been detected as carriers of E H cysts. Information as to whether these carriers were still employed in the kitchen was not available.

There is not cold storage available. Perishable articles and dairy products are received and consumed the same day. Food is conveyed to the wards on improvised trollies including operation theatre trollies.

Laundry:

The mechanical laundry is not being put to full use for want of staff and steam to run it. The laundry serves only the operation theatre. Receiving and delivery ends are not clearly demarcated.

Medical stores:

The accommodation in the basement is hardly adequate for the medical stores. Larger packages are stacked unopened because of inadequate storing facilities. In a separate

room, which has a window-air conditioner, preparations required to be kept under cold storage are stocked. The temperature of this room is not low enough for cold storage. Keeping of inflammable products in the same store is not free from danger.

#### Sanitation:

General sanitation is satisfactory. Incinerator is not being used for disposal of refuse.

#### Physical facilities:

##### Buildings:

More accommodation should be provided for O.P.D. to cater to the needs of Irwin and G.B. Pant hospitals.

##### Staff:

The staff of the hospital is functioning in air-tight compartments, the honorary staff and the full-time teaching staff of the Maulana Azad Medical College and the staff of the G.B. Pant Hospital. For efficiency of medical, surgical and specialist care, they should all work as one homogeneous unit. The staffing pattern for the medical college clinical departments should take into consideration the full-time staff at the G.B. Pant Hospital and they should be completely absorbed in the academic staff of the College. The honorary staff, though not full-time, should also be given teaching responsibility in the various clinical departments of the college.

The Committee feels that the functioning of the honorary system, as it exists in the Irwin Hospital at present, requires modification. Strict enforcement of the rules of the recruitment and appointment is necessary. Tenure system should be introduced. Honoraries should have the same code of discipline as the paid members of staff and fixed hours of work. The clinical responsibility given to the honoraries should be according to the recommendations of the Medical Council of India.

#### Equipment:

The equipment in the hospital requires replacement and modernization. A fairly large proportion of equipment is in a state of bad repair.

#### Laboratory and Radiological Services and Blood Banks

##### Laboratory:

The departments of Pathology, Microbiology and Bio-chemistry attached to the Maulana Azad Medical College have adequate staff and equipment. However, the control of these laboratories over the "clinical laboratory" service of the hospital is both inadequate and ineffective. The "clinical laboratory" is inadequate to cope with the quantum and the quality of work expected of them. The techniques used <sup>leave</sup> much to be desired. Only certain limited haematological investigations are available for emergency cases. The clinical Biochemistry laboratories are situated at



three different places. No adequate supervision of the quality of work of this laboratory can be undertaken by the parent department. While the standard of work in the Microbiology Department seems adequate there is lack of communication between the hospital and the parent Microbiology Department. No serious attempt is made to utilise the services for sterility control or for investigation of hospital cross-infection.

The Department of Biochemistry, Microbiology and Pathology undertakes training of technicians and at present there are 6 technicians under-training. They contemplate starting a course for a period of two years for B.Sc. Med. Tech.

While the service rendered by the Morbid Anatomy Department is excellent, the number of autopsies performed for the bed strength is very inadequate. An attempt should be made to increase the number of autopsies by offering a round-the-clock autopsy service to the hospital.

#### Blood Bank:

The Blood Bank depends mostly on paid donors. About 70% of their transfusion service is devoted to emergency cases. The Blood Bank also undertakes manufacture of infusions. This is a function of the Pharmacy.

#### Radiological Department:

Diagnostic and radio-therapy services are satisfactory. However, the therapy department

needs expansion by providing 20 beds for therapy cases.

#### Out-patient Department:

Out-patient departments are over-crowded. Accommodation is insufficient both in the waiting and consulting units. It is a common feature for more than one medical officer to share a table in the consulting room.

In the medical and surgical O.P.D., 2 units work at the same time - one unit deals with the old cases while the other attends to new cases. The consulting rooms are small and with the undergraduate students the whole area is over-crowded.

#### In-patient:

Hospital wards are over-crowded. As against the sanctioned strength of 1068 beds, the average bed occupancy is 1250. In between the beds, patients are kept on the floor. The verandahs are also used. A high rate of cross-infection is inevitable. The ward linen is in short supply.

#### Beds:

This hospital should, therefore, limit the admissions to the sanctioned bed strength. The policy with regard to admitting cases for investigation should be revised. Similarly all chronic cases for which nothing further can be done in a teaching institution, should be discharged.

#### Surgical care:

Surgical care is good though the operation theatre facilities are inadequate for the number of specialities. There is general

overcrowding in all the surgical wards and hence cross-infection is likely to occur.

Operation Theatres:

The number is inadequate for a large hospital with different specialities. There is no separate septic theatre.

Bacteriological investigations are not regularly carried out to check asepsis in theatres.

General hygiene is poor. Anti-biotics are used as a routine umbrella in surgical cases.

Central Sterilization:

There is no central sterilization except for autoclaving of dressings and linen for theatres. The person in charge of the sterilizer is untrained.

Obstetrics & Gynaecology:

Facilities for care of neonatals are poor. Accommodation is almost inadequate in the department for the number of patients. Cross infection is likely to be heavy.

Specialist care:

The reorganization and the development of various specialities in the Irwin and the G.B. Pant Hospitals is long overdue. All the specialities exist in both the institutions but a re-arrangement of the responsibility and the localization of services are needed. The out-patient Department should serve both the institutions. As the G.B.

Pant Hospital is catering to the needs of specialities of Cardiology, Cardiac Surgery, Neurology, Neuro-Surgery and Psychiatry, all in-patients requiring such attention should be treated in the G.B. Pant Hospital and staff of the G.B. Pant Hospital should attend the clinics in the common O. P. D. The physicians and surgeons of the Irwin Hospital should deal with only general medicine and general surgery or specialities other than the ones being developed in the G.B. Pant Hospital. Any equipment available for these specialities in Irwin Hospital should be transferred to the G.B. Pant Hospital.

#### Emergency service:

Accidents must be attended to by the specialists of both the institutions depending upon the nature of the emergency. The head injury service must be round the clock in the G.B. Pant Hospital.

#### Education and Training:

The Irwin Hospital is the clinical centre for the under-graduates and post-graduates of the Maulana Azad Medical College. There are no seminar rooms and clock rooms for the students in the hospital. The residential accommodation of the post-graduates, house-surgeons and registrars is inadequate. The post-graduate students should be considered as full-time residents in the clinical departments and should have patient care responsibility.

This institution should also take up the continuing education of the staff of the hospital, the general practitioners in the city and hospital administrators. The continuing education of the skilled and unskilled workers of the hospital should also be taken up to improve the efficiency of their work.

Nursing:

There is an excellent Nurses' Training School.

Future Development:

There should be no increase of bed strength in the Irwin and the G.B. Pant Hospital complex. The Accident Service Department however, needs expansion and augmentation. The efficiency of the hospital should be increased by eliminating the floor and verandah beds and modernisation of equipment and the general improvement in the discipline of the institution.

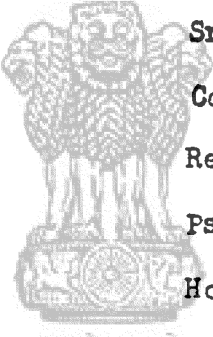
The future development of this hospital should be in conformity with the overall development of the health services in Delhi.

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G.B. PAT HOSPITAL27 Basic Data:

This hospital has 258 beds including 29 beds in the Nursing Home. These are provided in 7 general wards and the nursing home.

This is a hospital for different specialities. The number of beds in the different specialities and the number of units in each speciality are as follows:

Details of specialities	No. of beds.	No. of Units/ Teams for each speciality.	Composition of the Unit.
Psychiatry	34	1	 Sr. Consultant (Post vacant) Consultant - 1 Registrar - 1 Psychologist - 1 House Physicians - 2 - 3 Social Worker - 1
Neurology	38	1	Sr. Consultant - 1 (Post vacant) Consultant - 1 Lecturer - 1 Registrar - 1 House Physicians - 3 - 4
Neuro. Surgery	38	1	Sr. Consultant - 1 (Post vacant) Consultant - 1 Reader - 1 Registrars - 2 House Physicians - 3 - 4
Cardiology	38	1	Sr. Consultant - 1 Consultant - 1 Lecturer - 1 Registrar - 1

Cardio Thoracic Surgery	38	1	Sr. Consultant	- 1
			Consultant	- 1
			Lecturer	- 1
			Registrar	- 2
			House Surgeons	- 3
.O.T. Gastroenterology (Surgery)		1	Prof. of Surgery	- 1
			Lecturer	- 1
	35		Registrar	- 1
			House Surgeon	- 2 - 3
Gastroenterology (Medicine)		1	Addl. Prof. of Medicine	- 1
			Lecturer	- 1
			Registrar (cover N. Home cases)	- 2
			House Physicians	- 2 - 3
Metabolic	-	1	Unit of M.A M. College)	
.O.T.			Prof. of Medicine	- 1
			Registrar	
			House Physicians	
Nursing Home (Filling beds)	29	-	All treating units attend their own cases.	

The number of admissions during the year 1966 were 2324.

#### Out-patient service:

The number of new and old cases treated during the year in the different specialities is as follows:-

	Attendance			Daily average
	New	Old	Total	
Neurology & Neurosurgery	2358	5699	6057	20

-14-

Cardiology & Cardiac	1240	2110	5350	11
Gastroenterology (GE (Surg.))	676	388	1064	4

O.P.D. Started on  
7-2-66

### Psychiatry

Out-patient department is held in 4 small rooms of the Irwin Hospital O.P.D.

#### Laboratory service:

No information is available.

#### Radiology:

No information is available.

#### Operation theatres:

Of the 4 operation theatres, 2 are regularly working and the third is made use of when required. During the year 336 major and 450 minor operations were performed. One recovery room is provided at each floor of the operation theatre block.

Emergency & accident service - There is no casualty department in the G.B. Pant Hospital. All casualties are attended to at the Irwin Hospital.

Ambulance service - No spare ambulance is provided in the G.B. Pant Hospital.

#### Blood Bank:

The Irwin Hospital Blood Bank also caters for this hospital.



Medical Audit:

The Medical Audit Committee scrutinizes the medical records as and when considered necessary.

Nursing service:

Comprises of one matron, 10 nursing sisters and 51 staff nurses. There are no student nurses.

Laundry:

The hospital does not have a laundry of its own. Washing is done by Dhobis.

Patients' welfare:

Dharamsala attached to Irwin Hospital is made use of when necessary.

Central Sterilization Department is provided.

There is no incinerator in the hospital for disposal of waste. सत्यमेव जयते

Standing Orders:

There are no standing orders.

Physio-therapy Nil

Workshop Nil

Maintenance service is done by P.W.D.

Mortuary - No separate arrangement.

<u>Staff</u>	<u>Full-time</u>	<u>Honorary</u>
Medical including specialists.	Specialists 11	1 (on contract)
General Duty Medical Officers	General Duty Medical Officer -	
Registrars & House Surgeons.	Registrars 11 House Surgeons 22	

Para-medical	11
Ancillary	267
Ministerial	26

Budget and finance:

Total Budget	- 12,69,400
Establishment charges	- 10,00,000
Other charges	- 9,69,400
Stores & equipment	- 8,15,500
Food	- 99,000
Medicines	- 4,82,000

Future planning and development

Plan outlay is for Rs.85.52 lakhs of which Rs.66.12 lakhs is for capital works.

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Rs. in lakhs

Provision of cold storage	0.89
Airconditioning of Operation theatre and other rooms	25.83
Additional staff quarters	5.70
Laboratory and store block	12.00
Additional wing for nursing home and out-patient Deptt. block.	22.70

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**28. OBSERVATIONS:**

This is a hospital for special disciplines of medicine. It is an integral Part of the Maulana Azad Medical College complex. It is under the over-all charge of the Director-Principal of the Maulana Azad Medical College. An additional Medical Superintendent is in charge of the hospital. He is assisted by an Administrative Officer and a Matron. Full complement of Consultant staff has not yet been appointed. The discipline of Gastro-enterology, which was not originally included in the list of specialities to be located in this hospital, should be transferred to Irwin Hospital and developed there.

Immediate action should be taken to take the staff into the medical college and given them the necessary teaching designations.

**Out-Patients:**

The accommodation earmarked for specialised clinics at the Irwin Hospital is grossly inadequate.

**Laboratory Services:**

Provisions have been made for the staffing pattern of the G.B. Pant Hospital for morbid-anatomist, microbiologist and bio-chemist and they are designated as Associate Professors and they have academic designations. The laboratories at G.B. Pant Hospital are not at all developed for the specialities for which the staff has been recruited. The Committee, therefore, suggests that all these staff should be integrated with the parent departments of the Maulana Azad Medical College and a special laboratory be developed in the G.B.

Pant Hospital for the specialities located in this hospital.

Emergency Service:

There is no casualty department in the hospital even though neurology, neuro-surgery, cardiology and cardiac surgery units are located in this hospital. All head injury cases requiring surgery should be admitted directly to this hospital.

There should be a Coronary Care unit in the Department of Cardiology of this hospital, for round the clock service.

Medical Stores:

The accommodation for medical stores and storage arrangements are inadequate. Accounting system also is not satisfactory. Cold storage plant has not yet been commissioned. The Medical Stores are under the charge of a Pharmacist.

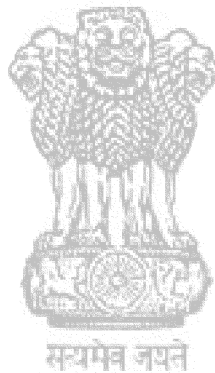
Staff:

Post-graduate training in the subjects of Neurology, Neuro-Surgery, Cardiology and Cardiac Surgery should be developed in this institution. The staffing pattern of these institutions will have to be carefully gone into and the ancillary personnel should be trained for the specific functions.

The present super-time scale Grade I, for the Consultants has been causing a lot of difficulties in the integration of the two hospitals and Medical College. As and when vacancies arise in future this anomaly should be rectified. The heads of these specialities should also be in the grade of Professors with a

scale of pay of Rs.1300-1800 plus non-practising allowance. The super-time grade I posts should be treated as selection grade posts open to all suitable officers in the service.

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HINDU RAO HOSPITAL29. Basic data:

This Hospital has 331 beds. They are provided in 11 wards.

The number of beds in the different specialities and the number of units in each speciality are as follows:-

	<u>No. of beds</u>	<u>No. of Units Teams for each speciality</u>	<u>Composition of the Unit.</u>
Surgery	66	2 units	Surgeon/Physician-I
Medical	101	2 units	C.A.S.Gr.1-2
Orthopaedics	32	1 unit.	
Eye	15	1 unit.	Surgeon-I
E.N.T.	13	1 unit	CAS Gr. I-1.
Dermatology	-		
Gynae. & Obst.	33	1 unit	Specialist - 1
Paediatrics.	50	1 unit	CAS Gr.I -2
Dental	3		Dental Surgeon
Psychiatry	-	Post vacant	
Anaesthesia	-	1 unit	Specialist -2 Grade I -2
Cardio Thoracic Surgery	10		
Plastic Surgery	-		
Any other - Side Rooms	- 5		

Nurse Sick Room- 3

The number of admissions during the year 1966 were about 11,700.

Out-patient service: The daily attendance (old and new cases) in the different specialities is as follows:-

Speciality	Attendance		
	New	Old	Total
Medical and Paediatrics	359	516	875
Surgical	23	51	74
Orthopaedics	24	61	85
Gynae. & Obst.	17	40	57
Eye	54	50	104
E.N.T.	47	38	85
Dental	26	19	45

Laboratory services:

The average work load and the staff posted in the different sections of the laboratory are as under:-

	Average daily work load		Staff posted	
	Out-patients	In-patients	Medical	Para-medical
Clinical	30	43	3	9
Haematological	70	81		
Biochemical	5	11		
Bacteriological	2	4		
Histopathological	0- 1	2		
Serological	2	8		

Radiology. The diagnostic section has 4 units- one each of 500 M.A., 2000 M.A. and 80 M.A. and 25 M.A. 2 Medical Officers and 7 members of para-medical staff are posted in this Department.

Radiotherapy: Nil.

Diathermy and short wave therapy is also provided.

Operation theatres: There are 4 operation theatres- 2 for general, 1 ENT and 1 minor. About 4000 operations are done in a year.

Maternity service: 33 beds are provided with 2 labour rooms- one clean and 1 septic.

Emergency and accident service is looked after by 4 casualty medical officers.

Ambulance service: The hospital has only one ambulance which is available for limited period.

Blood bank: During the year about 1700 units of blood were collected. More than 80% were from professional donors.

Medical Audit: Nil.

Nursing service: The hospital has 76 fully trained and 48 student nurses.

Medical Education: The hospital is not affiliated for any under-graduate study. It is, however, recognised for post-graduate study viz. M.S. (Surgery) and Diploma in Anaesthesiology. One post-graduate student for M.S. and two for diploma are registered.

Nursing Home: Nil.



Drugs and stores: The expenditure on medicine during the year was about Rs.1.74 lakhs.

Kitchen: A diet of 2700 calories per day per patient is supplied and the cost works to Rs.1.40. There is no dietician.

Laundry: Dhobies are employed by the hospital.

Patients' welfare: No arrangements for dharmasala.

Central sterilization Deptt.: Does not exist.

Physio-therapy: There is one trained physio-therapist.

Workshop: Nil.

Maintenance service is done by PWD staff.

Mortuary: Nil.

Staff:

		<u>Full-time</u>	<u>Honorary</u>
Medical including	Specialist	Senior -13	+ Junior 7
Specialist, General	G.D.M.Os.	28	
Duty M.Os. Registrars	Registrars	3	(under sanction)
& House Surgeons.	House Surgeons	10	
Para-medical	Nursing staff-	76	Class III Technical-46
Ancillary Class IV-191	(Ward boys/N/Orderlies	-75	
	(Sweepers -68, Cooks	-24,	
	(Chowkidars- 10, Dressers-4		
	(Dhobies- 4, St. Bearers- 6		
Ministerial		20	

Unions: There are unions of hospital workers,

Budget & finance:

Total Budget	- Rs.22,85,000
Estt. charges	- 12,96,400
Food	- 1,37,900
Medicines	- 4,72,800
Equipment	- 1,42,200

Future Development Programme:

All the proposed programmes of capital works are in respect of such services which are substandard for a busy hospital. Some of the projects are:-

	<u>Rs. in lakhs</u>
Completion of construction of Nurses' Hostel and School:	
Construction of OPD(4) storeyed block)	20.00
Construction of Mortuary-cum-post-mortem blocks	
Construction of wards for 200 beds (4 storeyed block)	Not given
Airconditioning of operation theatre block	-do-
Construction of overhead water tank	-do-
Construction of 4 storeyed block to house:	-do-

Pathology department:

X-ray Department

Doctors' recreation rooms and library

Medical store in basement.

### 30. Observations

The hospital is in an old building which accommodates certain departments. Additional space is provided by construction of multi-storeyed blocks in the campus. Future expansion is limited because of the uneven lie of the rocky landscape in which the hospital is situated.

Medical Superintendent is also a surgeon. He is assisted by the Assistant Medical Superintendent and Nursing Superintendent. There is no Administrative Officer.

Reception and enquiry is inadequate.

Medical records are not being maintained.

#### Medical stores and pharmacy

There is really no pharmacy as such but only a dispensary to distributes mixtures and tablets. Accommodation is very poor.

Stores are located in a small poorly lit and ill-ventilated room. The roof was leaking. The stock of medicines is not enough. It was reported that the stock held was sufficient for only two months. There is no officer in charge of medical stores. The method of storage and accounting procedures are unsatisfactory. Stock verification has not been carried out.

Kitchen:

No dietician is attached. The fuel used for cooking is soft coke. No records of medical check up of the kitchen staff is maintained. The general sanitation is poor. The utensils are not tinned properly.

Discipline:

The Committee witnessed a noisy demonstration held by Class III and Class IV employees' unions as the members entered the hospital. The hospital employees had their demands and it was reported that they created trouble off and on.

The buildings are out-dated but in view of the paucity of finances, they should be utilised for the time being. However, the future planning should include a very well developed modern hospital in this area to serve the whole of North Delhi as a referral hospital. The equipment is also out-dated and the hospital should gradually modernize its equipment. The staff is inadequate for giving efficient medical and surgical care and should be augmented.

Laboratory Service:

A junior pathologist in the grade of Assistant Surgeon is in charge of the department. The bacteriological laboratory undertakes routine service during the day. The quality of diagnostic services all round is poor. The space provided for various

sections is very inadequate and working conditions are not conducive to productive investigations to check the sterility in different sections of the hospital. It will be necessary to reorganize the clinical pathological services so that it can undertake many investigations with efficiency to serve as a referral sector hospital.

Radiology Department - X-ray Department does not provide emergency service. The department is ill-equipped and under staffed. This Department will have to be completely reorganised.

Out-patient Department is functioning under a temporary structure covered with cement as-bestos roof. Each doctor is provided with a small consulting room with a waiting room which is absolutely inadequate. Dispensary and dressing rooms are across the road in a shed. Emergency department is accommodated in two side-rooms of the OPD, part of which is used as a minor operation theatre.

The Committee was informed that construction of new OPD has been sanctioned.

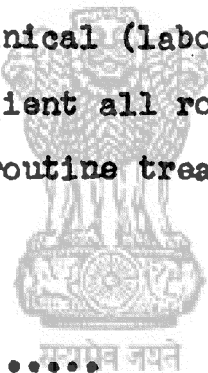
In-patients- The wards located in the old building have inadequate sanitary conveniences. Very few investigations are carried out. The treatment is based on clinical findings.

In the paediatric unit there are no arrangements for the care of the premature. Incidence of

cross infection is high. No arrangements exist for safe disposal of stools.

Obstetrics and Gynaecology - General sanitation and upkeep of the obstetrics and gynaecology section are poor. Cross-infection is a common occurrence.

The hospital is recognised for post-graduates in M.S.(Genl.) and Diploma in Anaesthesiology. One post-graduate in Surgery and two for the diploma course are attached. It is regrettable that the hospital is recognised for post-graduate studies when the clinical and para-clinical (laboratory and x-ray) departments are deficient all round and lack facilities for even routine treatment/investigation.



### INFECTIOUS DISEASES HOSPITAL

31. The Infectious Diseases Hospital is located in Delhi and is under the administrative control of the Delhi Municipal Corporation. It has 175 beds and is the only infectious diseases hospital in Delhi. The average normal occupancy is about 150 beds. The maximum number of patients during last summer went up to 250. It provides treatment for cholera, rabies, smallpox, and diphtheria. Tetanus patients are not admitted.

#### Laboratory Service:

There is no laboratory. All bacteriological work is sent to the National Institute of Communicable Diseases which functions from 10.00 A.M. to 5.00 P.M. In the clinical side room there is hardly any equipment.

The hospital prepares intravenous fluids required for cholera cases. The method of sterilisation for intravenous sets adopted in this hospital is most primitive.

The hospital has only one ambulance which is in a state of bad repair.

Budget: The total budget is of Rs. 6 lakhs of which Rs. 4.5 lakhs is for administration, Rs. 50,000/- for diet and the balance for the other expenditures.

#### Sterilisation of Equipment:

It is unsatisfactory. All the material is kept in one container. 20 or more intravenous sets are sterilised together in one waterbath. About a dozen tracheotomy tubes and the instruments are similarly sterilized.

#### Disinfection of blankets and mattresses:

There are no arrangements except natural sunlight.

The condition of this hospital is no better than what was described about Infectious Diseases Hospital in the Health Survey and Planning Committee Report (1961).

This hospital is ill-equipped to function as an infectious diseases hospital because of non-availability of adequate and round the clock service for bacteriological examination; lack of proper arrangements for sterilisation of equipment; and complete absence of disinfection facilities for hospital linen and proper disposal of wastes.

This is the only infectious diseases hospital in Delhi with facilities for teaching and training of post-graduates and under-graduates. In view of the fact that Delhi is the Capital of India with so many foreign missions, with an international airport which has to provide facilities for isolation and treatment of cases in emergency, immediate action has to be taken for modernising this hospital with adequate staff, laboratory and diagnostic services and efficient treatment with provision for paying patients.

#### SILVER JUBILEE TUBERCULOSIS HOSPITAL:

32. The Silver jubilee Tuberculosis Hospital run by the Delhi Municipal Corporation has a bed strength of 1113. Patients from all over Delhi are admitted in this hospital. Thirty beds are reserved for ESI patients. The hospital undertakes surgical work. The hospital is recognised for teaching under-graduates and post-graduates by the University of Delhi.



Admission Procedure:

For admission to the hospital, patients are referred from all the 8 tuberculosis clinics in Delhi. The criterion for admission is positive sputum. A waiting list is maintained. An Admission Committee with the Municipal Health Officer and Chairman and Superintendents of the Tuberculosis Clinics meet once a month to finalise the list, for admission. Emergency cases are admitted directly for a few days. Priority admission is possible when considered necessary for socio-economic reasons. The annual admission rate is about 2500. The usual stay in the hospital now is three months.

The laboratory is not equipped to handle the bacteriological and other work for such a big institution. There is no qualified bacteriologist in position.

Out-patient Services:

The clinic attached to the hospital looks after the urban area allocated to it as also the neighbouring rural areas. Besides undertaking diagnosis, the clinic also issues medicines. In all there are 8 clinics in the whole of Delhi for out-patient service.

Surgical:

The Surgeon in charge has limited experience in his speciality. About 700 patients need surgical treatment. Only about 250 Patients could be handled during the year. There is no Thoracic Surgeon in position.

Education and Training:

Since this is the largest tuberculosis hospital undertaking training of both under-graduate and post-graduates, it is essential that the staffing pattern of this hospital should be revised to suit its manifold

functions. The laboratory services need considerable strengthening.

#### NEW DELHI TUBERCULOSIS CLINIC

33. The New Delhi Tuberculosis Clinic was established in 1940 by the Tuberculosis Association of India. It is an out-patient clinic with emphasis on domiciliary treatment. It has 12 emergency beds. Patients requiring admission are referred to the Silver Jubilee Tuberculosis Hospital. Service, training, research and social welfare constitute the four pillars of the Centre's anti-tuberculosis programme.

The annual expenditure is about Rs. 7 lakhs out of which Government of India gives a grant of Rs. 4 lakhs.

The Delhi Municipal Corporation and the New Delhi Municipal Committee provide medicines for free distribution and some staff for domiciliary work. The staff appointed by them is directly paid by those organisations but they work under the Director, New Delhi Tuberculosis Clinic.

Nearly 3,000 persons currently under treatment are on the active list of the clinic. Patients report at the clinic for diagnosis and thereafter once a month to collect the medicines. For demonstration purposes the domiciliary treatment scheme under this clinic is confined to a population of about 8 lakhs. The area under cover is divided into 12 zones, each under a Health Visitor. They visit the patients at their homes. Medical record of each patient is maintained at the out-patients through which a watch is kept of those who fail to report at the Clinic for medicines on the

specified date. Defaulters are contacted by the health visitors and where the health visitor fails, the medical social worker and the chief public health nurse pay a visit. This enables the clinic to maintain contact with about 90% of cases.

In the out-patient department, health education is given. The general practitioners are encouraged to sent bonafide patients for X-ray examination on nominal charges.

#### Laboratory services:

The clinic has a well equipped laboratory for bacteriological and epidemiological work. It is also equipped with mobile mass X-ray unit for survey work.

BCG inoculation is given to contacts. Besides, the domiciliary treatment the Clinic undertaken field research and trial on new methods of treatment.

The clinic imparts training to health visitors. It also participates in post-graduates training in D.C.T.D. of the Delhi University.

#### TUBERCULOSIS HOSPITAL, MEHRAULI:

34. The Tuberculosis Hospital, Mehrauli is run by the Tuberculosis Association of India. It has an accommodation of 306 beds out of which 110 are free beds. The rest are reserved for different agencies e.g. C.G.H.S., E.S.I., Reserve Bank of India, N.D.M.C. and Railways. The total expenditure is Rs. 14 lakhs, of which Rs. 5 lakhs are paid by the Government of India and the balance is met out of the earnings from treatment of patients. The cost per bed per day is worked out on the basis of the total expenditure. The current cost is Rs. 10.64 p. The cost

of diet is Rs. 2.25 p. per day.

Besides the Hospital Superintendent there are 8 other medical officers. On the administrative side the Superintendent is assisted by an administrative officer (Post vacant at present) a Matron, a head clerk, 2 UDCs, 6 LDCs, and one accountant. Other hospital staff is sanctioned on the scale of one nurse for 10 patients; a sister for 100 patients; one ward boy and one sweeper for 10 patients with 10% leave reserve.

#### Laboratory and Radiological Services:

The hospital is equipped with a laboratory and X-ray. The laboratory undertakes all bacteriological and bio-chemical work.

Surgical work is undertaken by the hospital superintendent twice a week. A part-time Anaesthetist is engaged for operative work.

The hospital is running an out-patient clinic for the South Delhi area. For admission to the general beds a waiting list is maintained by the Tuberculosis Association of India. The waiting period is about three to four months.

#### MENTAL HOSPITAL, SHAHDARA

35. Mental Hospital, Shahdara was started in 1966 by Delhi Administration. It has 160 beds, out of which two-third are chronic cases and the balance one-third are acute cases under treatment. In the next phase 170 beds for chronic patients and 20 beds for voluntary patients are being added. Ultimately the hospital will have 400 beds.

Staff:

The institution is headed by a Medical Superintendent who is a well qualified Psychiatrist. He is assisted by another Psychiatrist and four Assistant Surgeons.

Laboratory and Radiological Services:

Pathology laboratory is under an Assistant Surgeon. There is no radiological service.

Nursing Services:

On the nursing side, there is an Assistant Matron assisted by one sister, 4 female staff nurses for female wards, and male nurses for the male wards. The nurse patient ratio is about 1:10.

The total budget is of the order of Rs. 6 lakhs. Staff quarters are yet to be constructed.

Out-patient Department:

The hospital has psychiatric clinic. Patients for admission are referred from other hospital out-patients.

The hospital is associated with Maulana Azad Medical College for teaching.

Modern mental health services require a preventive and public health approach. Psychiatric clinics should be established in all general hospitals with necessary beds to give early diagnostic services and treatment. The institutional care should be specifically reserved either for incurables and/or cases which require treatment in a mental hospital for a period over three months. This hospital, therefore, should be inter-linked with other psychiatric clinics and teaching institutions in the city and utilised for

teaching and training of under-graduates and post-graduates. It, therefore, requires a laboratory and other diagnostic services, besides consultant services in other disciplines for the patients of this institution. Cases requiring surgical treatment should have also an opportunity of such treatment. The Govind Ballabh Pant Hospital has a psychiatric, neurological and neuro-surgical department. This hospital, therefore, should be associated as a teaching centre for Maulana Azad Medical College and should work in close collaboration with G.B. Pant Hospital.

In view of the recent advances and changes in the Mental Health Acts in the world, voluntary boarders should be encouraged and suitable arrangements made for special accommodation.

TIRATHRAM SHAH CHARITABLE TRUST HOSPITAL & NURSING HOME:

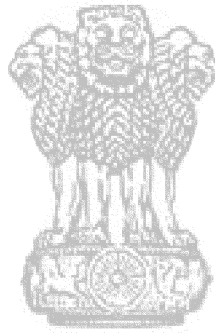
36. The Tirathram Shah Charitable Trust Hospital and Nursing Home was established in 1955. It has in-patient facilities for 110 patients, out of which 28 are nursing home beds. Thirty-five beds are reserved for ESI Scheme; 6 are subsidised beds and 41 are general wards free beds. The hospital has a panel of 35 consultants in various specialities. It runs its own diagnostic services (Laboratory and X-ray). It has a Neurology, Physiotherapy and Artificial Limb Unit.

Out-patient Department:

Each consultant attends OPD in his speciality twice a week.

The charges for the Nursing Home are Rs. 32 per day for room and diet. Charges for professional attendance are extra. The patients in the Nursing Home have to pay for all services.

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सत्यमेव जयते

### 3.3 The people speak at Public hearing

37. The Committee invited senior officers connected with health care programmes in different Ministries, hospital administrators, persons with long association with activities in the field of medical care and medical education and representatives of the Indian Medical Association and the Indian Hospital Association to give evidence. They sent written memoranda and also supplemented these with oral evidence. Theirs was the medical point of view. One specific question asked was to suggest the extent to which the administrative organisation of hospital services should be modified to overcome the existing shortcomings and how better collaboration and coordination could be brought about among different agencies responsible for medical care in Delhi. The Committee also received written and oral evidence from the former Union Minister for Health, Dr. Sushila Nayyar. Dr. R.F. Bridgman, Chief of Medical Care W.H.O. Geneva, during his recent visit to India, also discussed with the Committee.

Many lay witnesses came forward to tender written and oral evidence. They constituted a broad cross section of general public, CGHS beneficiarises, members of Parliament and social workers. Some did not confine to the specific issue of service to patients in Delhi hospitals but touched upon medical care in general and functioning of the CGHS in the particular.



In many cases their view were stated to be based on personal experience. It was alleged by many that the hospital staff was generally callous. The Committee called upon the representatives of hospital para-medical and ancillary staff to express their views on the issues touched in the evidence. The evidence is summarised below as in the following paragraphs.

Standing orders

38. No hospital had any standing orders defining the duties of various members of the staff. In the absence of these, it was impossible to pin-point responsibility for acts of omission and commission.

Public relations

39. Public relations was a major casualty in the hospitals. Most of the witnesses spoke of lack of directions for the guidance of users in any hospital. There was no easy way of getting information either on telephone or by personal contact. The need of a Public Relation Officer was keenly felt.

It was brought out that the hospital receptionist should have full information of the hospital and its patients.

Individual hospitals should have information centres and should themselves arrange to refer a case to another hospital, as required, instead of telling the patients or the relations to make such arrangements. The need for a booklet giving information regarding the facilities available in hospital was also felt.

It was suggested that during visiting hours a medical officer of each ward should be available to answer queries of relations.

Patients relatives should be allowed to stay with seriously ill patients.

ndifferent  
ttitude

40. It was reported that doctors and nursing staff generally lacked the spirit of dedication and sense of responsibility towards the patients. Physicians did not care to understand the patients point of view or win their confidence. Courtsey and humility were sadly lacking.

It was also pointed out that doctors and Class IV staff in hospitals were not only unsympathetic but also rude. People felt so disgusted and frustrated that they did not do anything to seek redress. Lack of supervision by hospital administrator encouraged indiscipline. The differential treatment given to the high and the low in the hospital undermined discipline. Even elementary discipline was lacking.

It was contended that allegations of indifference or negligence on the part of some medical and para-medical personnel in hospitals deserved serious consideration. They must be some direct and quick method of dealing with unprofessional and unethical conduct on the part of attending personnel. Hospital Administrator should personally attend to these.

Some witnesses maintained that the lack of promotion prospects for the para-medical staff lowered their morale and this was an important factor contributing to their disgruntlement. They felt that there was room for improvement in the terms and conditions of service of hospital staff.

Hospital subordinates were not treated as part of the "hospital family". The old time 'officer - subordinate' relationship should be replaced by a 'senior-junior' relationship. Orientation of all medical and para-medical staff was also suggested.

It was also stated by some that unprofessional conduct and personal rivalry among the doctors in the hospital had lowered the efficiency of the hospital service.

Some witnesses alleged that there were malpractices in Government hospitals such as admitting cases by taking fees. It was pointed out that the Medical Officers in receipt of non-practising allowance were indulging in such practices in Government hospitals.

Amenities 41. Every hospital should have a Cooperative Drug Store for sale of medicines and other toilet goods.

A suggestion was made that the taxi/scooter-stand outside the Hospital should be under the control of the hospital.

A witness pointed out that lifts in the hospitals were not allowed for visitors. Old, infirm and disabled visitors had to use the staircase to see the patients.

The hospital concerned should arrange for conveyance of dead bodies of patients dying in it.

#### Sanitation

41A. Surgical aspsis was neglected. Even elementary cleanliness was lacking. Sanitary annexes were appallingly dirty. Taps were often missing.

Drinking water facilities were not always available. This was attributed mostly to the lack of supervision of general sanitation. It was suggested that in every ward some persons should be entrusted with the duty of looking after sanitation.

Soiled dressings were thrown into refuse, incinerator was not functioning in any hospital.

#### Welfare of patients & visitors

42. A number of patients come from the outlying areas and adjoining districts. The need for a hostel type of accommodation (Dharamsala) was very keenly felt in all hospitals.

Outside the hospital gate food vendors were a nuisance. Exposed food was sold by them. The hospitals should run cafetaria or canteens where food and eatables were available to patients and visitors.

Stores &  
equipment.

43. Pilferage of medicines was common and this was done with the connivance of senior staff. The equipment was not properly maintained and medical records were highly unsatisfactory.

There was no standard laid down for equipment. Poor quality of drugs and equipment was purchased because of the acceptance of lowest tenders. Facilities for storage of sera and biological product were inadequate in some hospitals.

Hospital  
Staff  
Welfare

44. The welfare of low paid staff in the hospitals needed attention. Top priority should be given for residences.

Officers should listen to the genuine grievances of their staff (Promotion avenues from Class IV to Class III may be considered). The special facilities afforded to nurses and medical students for treatment in hospital should be extended to para-medical and ancillary staff.

It was pointed out that in one institution amenities like sanitary convenience and a place for taking lunch and a recreation room were not available.

'Risk allowance' for hospital staff was advocated.

Industrial  
Disputes  
Act.

45. Staff should be encouraged to feel as part of the institution. This could be done by constituting work councils. If the head of the Institution was sympathetic, there would be

no need for trade unions.

In regard to the application of Industrial Disputes Act to the hospitals, the reaction of the witnesses was mixed. By and large, the medical administrators and the beneficiaries were of the opinion that the hospital service should be declared as an essential service and that hospital employees should not have the right to strike. One witness however stated that without resorting to Industrial Disputes act grievances were not likely to be redressed.

Medical  
Service

46. The over-crowding in the OPDs and inadequacy of waiting space were universally brought out by the witnesses.

The specialists' attention was not available even for serious patients. As the out-patients had no referral system such cases which needed to be seen by a specialist were often disposed of by the junior staff.

Over crowding in the outpatient department of the hospitals would continue as long as polyclinics and health centres at the periphery were not organised.

Over crowding in general wards resulting in-patients being left on the floor and in the verandahas, even in winter, was brought out by most witnesses.

Food served in wards was unpalatable.

A patient could go to any hospital of his choice as there was no provision to scrutinize cases at the periphery and channelise the flow to appropriate hospitals.

The hospital services should be available on equal footing to all patients. Type of accommodation and nursing facilities should be provided according to the disease and not on the economic status of the person. Special and private wards should be discontinued.

It was also suggested that there should be closer liaison between practitioners and hospitals. Practitioners should be allowed to use the laboratory and X-ray facilities directly.

To enable proper utilisation of costly hospital beds adoption of progressive care system was essential.

A persistent complaint was that Class IV and Class III staff in the wards did not attend to the needs of patients unless they were tipped.

It was stated that the honorary system in hospitals was outmoded and that it should be discontinued. The honoraries did not take any interest in the patients and some of them took away the patients to their clinics.

Emergency & accident service.

47. Emergency service should be provided at the Regional Hospitals. Emergency department should be properly equipped and adequately staffed whenever an ambulance was detailed

to collect a casualty, a doctor should go in the ambulance.

The ambulance service maintained by different hospitals was far from satisfactory. In a hospital, out of two ambulances one was always kept back and not allowed to be used for patients until the second came back.

Education and training.

48. Absence of orientation training among the hospital staff was brought out by almost all witnesses. It was suggested that there should be periodical refresher courses and orientation training of all staff; in particular the para-medical and ancillary staff should be imparted training on courteous behaviour. It was also brought out that the operation theatre technicians working in operation theatres, central sterilization service etc. did not get proper training.

POSITIVE HEALTH:

There was no organised system to impart health education or for immunisation. The school health services were rudimentary.

Local Services Coordination.

49. Almost all witnesses were critical of the location of hospitals in Delhi. Some considered it most illogical. They referred to the existence of two big hospitals across the road with a total bed strength of about 2000 in South Delhi and to the construction of G.B. Pant Hospital of 300 beds in the compound,



of the Irwin Hospital which had already over 1000 beds. On the other hand there was hardly any hospital service in West and North Delhi particularly in the New colonies.

To provide medical care for the public all over Delhi, within the available resources it was imperative that there should be a zonal distribution of general hospitals, poly-clinics and peripheral health centres.

There was a tendency to multiply similar specialities in several institutions instead of concentrating these in one or two places.

There had been no technical inspection of the hospitals for many years and that was why the services had deteriorated.

The necessity for a very close cooperation and collaboration of the health services in Delhi was stressed by all witnesses. There would be no improvement unless the hospital services were coordinated and developed on a zonal basis. Even representatives of controlling agencies agreed with this opinion and said that there should be no difficulty to coordinate the services.

The Committee was informed that the Superintendent Medical Services, Delhi Administration had no control over the major hospitals under Delhi administration and was only responsible for looking after the police, jail and mental hospitals.

Central  
Health  
Bureau

50. A suggestion put forward was that some kind of Central Health Advisory Bureau for Delhi be established whence all information regarding hospital facilities could be obtained. It should also act as a bed bureau and direct patients to the appropriate hospital.

Autopsy

51. In regard to the introduction of compulsory autopsy in respect of deaths in hospital, diverse opinions were expressed while all witnesses agreed that autopsy was in the interest of medical science and that knowledge acquired from such autopsies would contribute to better medical care, they realised that it had not been possible to encourage public cooperation by persuasion. Some felt that legal provision seemed to be the only solution. Other doubted if public opinion would favour such legislation. Further a discriminatory measure applicable to deaths in hospitals alone was not likely to be tolerated by the society. Public needed a lot of education to create proper motivation.

Hospital  
stoppages

52. A suggestion was made to place a small levy for out-patients and in-patients treatment to augment hospital revenues.

Review  
Committee.

53. The Hospital Review Committee may be made a permanent body.

Central Govt.  
Health Scheme.

54. Doctors were not available on emergency duty. There was need for stricter supervision of the working of the functional dispensary.

The medical officers were reluctant to undertake domiciliary visits. To prevent misuse of the privilege of such visits it was suggested that either a nominal charge be levied or that defaulters be debarred from the benefit of domiciliary visits.

Doctors prescribe medicines without listening to or examining patients.

Behaviour of Class IV staff in dispensaries left much to be desired.

It was suggested that the CGHS doctors should, like family physicians, visit the beneficiaries at their residences regularly and not restrict the attendance at home to the first one or two visits.

C.G.H.S. hospitals should be established in those outlying colonies which at present had no hospital services.

It was alleged that specialist service to C.G.H.S. beneficiaries was inadequate in Willingdon Hospital. The Hospital staff was neglectful and reported in-correctly. The sterilisation system was non-existent. In the prescribing of medicines discrimination was made between gazetted and other staff.

### 3.4. Summary of findings.

#### Administration

55. The efficient administration of hospitals in Delhi requires immediate attention. The functions to be discharged by a hospital superintendent relate to office administration, accounts, personnel management, various types of stores, transport, laundry and dietary services, water supply, electricity, maintenance of buildings and plants, future planning, development etc. The medical superintendent, loaded with clinical and teaching responsibilities, has not been able to devote personal attention to the administrative matters and has to rely mainly on few junior and often inexperienced team of administrative staff.

Administrative functions like finance, supply and establishment, maintenance of buildings and plants, catering and food supplies, clerical and recording are wholly lay in character, but a number of these still continue to be performed by doctors, even in hospitals where an administrative officer is posted. These duties can with advantage be delegated to the lay administrator.

Standing  
orders.

56. None of the hospitals have any standing orders clearly defining the duties of the

various members of the staff. In the absence of such orders, it is impossible to pinpoint responsibility for acts of omission and commission. The Committee notes that the Director General of Health Services has been advising the Medical Superintendents of all hospitals to prepare complete standing orders and generally tone up their efficiency since 1963. (See Annexures).

9. There are also no manuals available for the guidance of the staff.

Stores and  
equipments.

57. The accounting procedure of different types of hospital stores and equipment is below par owing to lack of trained staff and absence of supervision at officers level.

Accommodation for stores (including cold storage and shelves) is inadequate in all hospitals. No special arrangements exist for storage of inflammable materials, gas cylinders and acids.

There is hardly any standardisation of scales of equipment, furniture, medical stores, diet and administrative services.

In all institutions visited, the Committee was informed of the delay in the procurement and receipt of supplies by hospitals from different sources. The quality of stores etc. varies from institution to institution. Each hospital has its own list of drugs. It independently issues rate enquiry, calls for quotations from local dealers and finalises the terms of procurement.

Delay and irregularity in the supply of medical stores by Medical Store Depot, Karnal, leads to shortage of a substantial number of items. The hospitals resort to frequent purchases in small quantities, thereby spending more money.

The routine prescribing of drugs by brand or proprietary names further increases the cost of treatment. Various hospitals have different amounts allocated for drug bill.

Stores worth lakhs of rupees are held by store keepers, pharmacists etc. without an experienced store officer to take full-time charge.

The supervision at officer's level, where it exists, is found to be part-time and casual.

Another shortcoming noticed in almost all hospitals in the absence of repairs and maintenance service for hospital equipment and appliances. As a result costly items of equipment often remain unused and neglected.

Maintenance

58. Maintenance of buildings in general and of sanitary services and water supply in particular, is poor because the maintenance

staff is under PWD and not under the control of the medical superintendent.

Internal -  
communica-  
tion.

59. Internal communication facilities are limited to a few telephones and messenger service. No hospital has any paging system for the purposes of establishing immediate contact with any specialist or other medical officer required in an emergency.

Sanitation

60. There is considerable room for improvement in general sanitation of the hospitals. Regular attention to bath rooms and W.Cs. supervision over collection and disposal of refuse and sanitary conditions in and around the kitchens and canteens is needed. There is hardly any hospital which disposes of refuse by incinerators. The dead tissues removed from patients such as an amputated limb or placenta (in maternity hospitals) and soiled dressings and bandages are thrown into the public receptacles and sometime littered on the road.

In Lady Hardinge Hospital a large area of the hospital compound is occupied by unauthorised hutments. Apart from denying the use of much needed land for constructional requirements of the hospital, the hutment dwellers create insanitary conditions and difficulties for administration.

Kitchen &  
diet.

61. Most hospitals have one central kitchen. In some there is also a special one. All hospitals have one or more dietician, steward/ house keeper and cooks. These are adequate for preparing menus, supervision of cooks and for actual cooking. The dietician in many cases is also responsible for actual procurement, quality control, stocking, issue and accounting of rations. Physical facilities for the kitchen in the form of ration stores, cold storage, hot cases, furniture, and food trolleys are inadequate in some hospitals. Holding of reserve rations for emergency is not in practice as a general rule.

Fresh rations are procured daily. Here again in some hospitals the quality and quantity are checked at the level of the steward or head cook. Milk is invariably checked only by the head cook, as it is delivered by Delhi Milk Scheme in the early hours of the morning. No laboratory checks on the quality of milk are carried out. Thus there is every possibility of pilferage of fresh supplies.

The general sanitation of kitchens is good only in two hospitals. In the others it needs considerable improvement. Fly proofing, wearing of aprons and caps by cooks, maintenance of health and inoculation records of cooks- these



measures do not exist in all the hospital kitchens. In the only hospital which maintains health records of cooks, the latest record is  $1\frac{1}{2}$  years old and show two or three cooks to be carriers of *Entamoeba histolytica* cysts. Coke and coal are still being used in some of the kitchens resulting in smoke nuisance.

Of all the hospitals visited only one hospital had two food trolleys with thermostatic control. Others had a few trolleys without such control. Still others use improvised ones including operation theatre trolleys. One hospital had only tiffin carriers. So the prospects of the food remaining hot till it reaches the patients are not very bright. The procedure for despatch of food to the wards is not uniform. In some cases the ward staff collect the food from the kitchens; in others, the kitchen staff deliver the food at the wards.

#### Laundry

62. Most hospitals employ Dhobis for washing hospital linen. The quality of wash is poor. Mechanical laundries where installed are not being fully utilised due to lack of power and staff.

No hospital has arrangement for disinfection of mattresses and blankets.

Transport

63. The hospitals are generally badly off for transport service. One or two vehicles, which the hospital has, are most of the time off road because there are no facilities at all to attend to repairs. Most of the ambulances are old. Breakdown being frequent, the ambulance service is very poor.

Public relations.

64. Reception and Enquiry. This is one of the most important requirements of a hospital to ensure good public relations. Lack of good public relations in Delhi hospitals has been the subject of criticism in the press in the past and has also been discussed in various meetings of the Superintendents of hospitals with the Director General of Health Services. In spite of this, reception and enquiry is still not adequately organised in any of the hospitals. A well organised reception and enquiry creates the first impact on the public in their contact with the hospital. The staff at present detailed is neither competent nor conscious of their responsibilities. Staffing pattern of medicosocial workers is neither uniform nor adequate.

65. Recreational facilities for patients in wards need improvement. There are very few radion, indoor games or reading material. Supply of magazines is an exception. Hardly any library for patients exists. The donations raised in hospitals are not by any means enough to provide

amenities. Occupational or diversional therapy facilities do not exist.

There are no arrangements for safe custody of patients' personal clothing and valuables.

It is understood that patients' and relations' complaints are heard and attended to by the Medical Superintendent, Deputy Superintendent or other members of staff. There is no uniform system prevailing in all the hospitals.

Sign posting and other devices to guide patients and visitors within the hospital are available but need improvement in some hospitals.

Barbers' services are provided almost entirely on payment. Some hospitals have licensed barbers who are permitted to work in the hospitals and others have engaged barbers on contract.

Very few hospitals have got gardens and lawns worth the name. Horticulture receives scant attention and yet this can contribute so much to add cheer to the patients' existence. It is understood that all malles working in the hospitals come under the CPWD and that their services are entirely unsatisfactory.

Provision has not been made in all the hospitals for cycle stands and car parks. In the absence of these, cycles, scooters, motor cycles and motor cars can be seen parked all over the hospital. Many cycles, particularly those belonging to the staff, are kept inside the hospital buildings adding to the general insanitary conditions.

No hospital has a well organised Dharamsala for use of relatives of patients coming from distant places except at the Irwin Hospital.

Very few hospitals have canteens for the use of relations of patients or even the hospital staff.

Public telephone booths are not available in all hospitals.

Uncontrolled traffic of visitors causes disturbance to those who are really ill.

Hospital welfare committee hardly exists in any hospital.

Welfare and discipline of staff.

66. Unions, recognised and un-recognised, exist in all hospitals and do often cause trouble to the administrative authorities. Medical Superintendents have all complained about lack of discipline among staff, particularly Class IV

Employees, and expressed their sense of frustration at their helplessness to control them. No hospital has a full time personnel officer who can attend to the welfare and discipline of the staff.

There is considerable shortage of residential accommodation. The accommodation provided for essential staff, e.g., nurses, house surgeons, registrars and certain Class III and IV employees, who are expected to be available round the clock, is at present grossly inadequate. Similarly, essential members of the senior staff, who are likely to be called over to the hospital at short notice at any time of the day, do not have accommodation near enough to the hospital.

No welfare or benevolent fund exists for financial assistance to members of the staff in distress or for providing recreational facilities.

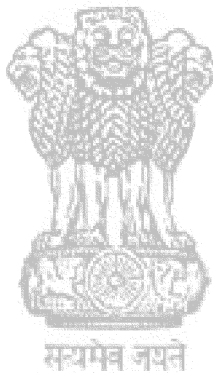
67. The maintenance cost per bed varies from hospital to hospital.

There is no cost accounting for any of the hospital services. Breakup of costs under different components which go to constitute various services is not available. Further, the staff and services are common for outpatients and inpatients.

Budget  
and cost  
accounting

No study has been made of the expenditure on outpatients which should be excluded in reckoning the cost per bed. The current basis of working out the hospital bed cost by dividing the total expenditure by the number of beds, without taking into consideration the outpatient expenditure is incorrect.

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### Laboratory Services

68. The hospitals in Delhi can be broadly classified in two categories:

1) Hospitals like the Willingdon, the Safdarjang, the Hindu Rao and the Gobind Ballabh Pant, whose primary duty so far is "patients care" but who also undertake training of varying numbers of postgraduates in different Specialities.

2) Institutions like the A.I.I.M.S., Maulana Azad and the Lady Hardinge, which are primarily teaching Institutions with well organised Departments of Pathology, Microbiology and Biochemistry.

The pattern of organisation of laboratory services in these two types of Institutions has been distinctive. However, "Clinical Pathology" has been neglected in both these categories of hospitals. In the first there has been no planned programme of development of clinical laboratory services.

One would like to emphasise that the word "Clinical Pathology" has lost its real connotation. Under its broad heading are included Clinical Haematology including Blood Bank Service, Clinical Microbiology including Parasitology, Virology and Immunology, Morbid Anatomy including Histology and Autopsy Service and Clinical or Chemical Pathology (Biochemistry).

Under the existing set up, these Departments seem to occupy un-attractive and inadequate hospital space. There is no schedule of the staffing pattern, both for the technical and

non-technical personnel and the administration in general seems to patronize their existence without giving much thought to their requirements. There has been no planned or effective development of Specialities like Clinical Bacteriology, Clinical Haematology, Biochemistry and Morbid Anatomy with the result that in many of the hospitals, they have neither the trained technical staff nor the efficiency to perform their manifold duties. It is thus necessary to ensure that such hospitals have a complement of staff which will undertake efficiently the investigations relating to the hospital patients.

As is being recommended by this Committee, it would be extremely desirable to integrate, the Willingdon Hospital with the Lady Hardinge Medical College, the AIIMS with the Safdarjang Hospital and the Gobind Ballabh Pant with Maulana Azad Medical College. The Hindu Rao Hospital should continue to remain a non-teaching hospital. However, the immediate need is to upgrade the quality of different laboratory services in the Willingdon, the Safdarjang, the Gobind Ballabh Pant and the Hindu Rao Hospitals.

As regard the second category of hospitals, while the specialised services like Morbid Anatomy, Microbiology and Biochemistry



are well organised by the respective Departments of the College, one of the greatest lacunae in all the attached hospitals is the lack of organisation of proper services for "routine laboratory" work. For the sake of achieving "patient care" of a high order, it is essential that the parent Departments must be made entirely responsible for the quality of the hospital services offered by the so called "clinical laboratories". This can be easily achieved with minor addition to the staff.

#### Radiological Department

69. Diagnostic: In all hospitals diagnostic radiology departments have a very heavy load to carry. Insufficiency of qualified radiologists and trained technical personnel prevails everywhere. Some hospitals do not provide emergency service. In many hospitals there are no arrangements for proper filing of records and maintenance of X-ray photographs. These are sent to the wards or out-patient departments as the case may be, and are disposed of or destroyed in the next 4 to 5 years.

For special investigations the waiting period varies from 7 to 20 days in different hospitals. It is noticed in one hospital that costly beds are kept occupied for days together by patients admitted for special radiological investigations.

Some hospitals do not have full complement of equipment.

70. Radio-therapy: In most hospitals it is both inadequate and ineffective.

The departments of radiology and clinical pathology in all the hospitals require complete overhauling.

#### Blood Bank

71. There is no coordination between blood banks of various hospitals. The annual output ranges from about 2000 units in a medium sized hospital to about 7000 units in the bigger hospital, with 30 to 150 bottles respectively in stock at any one time. Professional donors form the main source of blood. This is a very unsatisfactory situation. The voluntary system has not taken root so far. Another neglected source is the tapping of the relatives of patients.

Blood matching is done by slide agglutination method which is considered unsatisfactory.

In some hospitals the blood bank service also prepares their infusion fluids which is really the function of the hospital pharmacy.

Facilities for proper control of non-pyrogenicity, sterility and toxicity are not

available. In the absence of any systematic recording, the extent of reactions from blood transfusion is not known.

The blood banks do not have proper washing machines. A steady supply of other essential equipment and anti Rh serum is lacking.

The existing facilities of blood bank in individual hospitals in a small way meet the immediate requirements of the institution. These cannot be said to be altogether satisfactory.

#### Medical Service

72. Out-patients: The congestion at outpatients is universal. All types of cases, minor, serious acute and chronic report at the hospital out-patients. The accommodation is woefully lacking not only for waiting but also for consulting rooms. Sharing of a table by more than one medical officer is a common feature which is not conducive for privacy and individual care.

Guidance to outpatients is not satisfactory.

The diagnostic services are inadequately staffed and equipped. Even available technicians do not possess sufficient technical skill. There is no proper supervision and guidance. Accuracy of reports cannot always be assured.

73. Inpatients: Overcrowding in wards in all hospitals is a normal phenomenon. Besides extra beds in verandahs and corridors, floor is frequently used in many hospitals.

All types of cases, serious, sub-acute, chronic and those who only require investigation admitted in the same ward, are treated side by side.

Nursing and other hospital services being not adequate, the care of the acutely ill patients suffers. None of the hospitals have adopted the system of "Progressive patient care". In this system the inpatient are is divided into separate sections, usually three in number. The first of these is the intensive care unit which takes patients in the acute stage of illness and gives a high degree of nursing and medical care. The second is the intermediate unit. The third is the convalescent unit, which takes patients who have nearly recovered and need the minimum of care.

Occupation of costly hospital beds by all types of cases, not only results in overcrowding but also necessitates provision of extra beds for emergent admission. This puts strain on staff and delays admission of cold cases.

74. Paediatric Service: Over-crowding is noticed generally in all paediatric units.

Cross-infection is common.

The Micro-technique laboratory in this unit is not of much help because of insufficient equipment and shortage of technicians. Photo-electric colorimeter, flame photometer etc. are either not available or remain out of order for months on end.

Clean linen is in short supply.

Toilet and washing facilities are inadequate.

Nursing service is also inadequate.

For mothers to attend on their children, suitable place and sanitary facilities are not provided in or near the ward.

Separate paediatric surgery facilities are not available in some hospitals.

75. Nursing Service: In view of the general shortage of trained nurses in the country, there is no alternative for these large hospitals but to depend largely on training their own nurses. efforts in this direction are at present not satisfactory. For various reasons most of these

hospitals have not undertaken the training of nurses to the limits of their capacity. The major difficulty in the way of implementing the training programme appears to be the shortage of residential as well as technical accommodation required for this purpose.

All India Institute of Medical Sciences has not training programme for nurses and the hospital functions with fully trained nurses.

The nurse patient ratio in all the hospitals is one nurse to 3-5 patients.

The Committee noticed that married nurses are not usefully employed mainly because of lack of residential accommodation in the hospital and also because of their not being available for duty all the 24 hours. Turnover of staff nurses in some hospitals is greater than in others because of lack of accommodation. In these hospitals, hostel accommodation for nurses is being extended. In one hospital this still remains a big problem. Nurses and student nurses are scattered in different places.

Nursing standards are poor. The administrative control by the Matrons is almost lacking. The general cleanliness of the wards, theatres etc. depends on the administrative control which the Matron is able to exercise.

### Surgical Service

76. The surgical services consist of general surgery and allied disciplines like orthopaedics, ear, nose, throat, eye, obstetrics and gynaecology etc. together with supporting services like laboratory and radiological services, anaesthesiology, operation theatres, central sterile supply department, emergency and accident service etc. All these services are available in the hospitals in Delhi, the quality of service provided in some hospitals leaves much room for improvement due to shortage of qualified and experienced specialists, well trained technicians, dearth of modern equipment and inadequacy of supporting services.

The position is further aggravated by the anxiety of these hospitals to develop special disciplines like neurosurgery, cardiothoracic surgery, urology, plastic surgery etc.

### Anaesthesiology

77. The department of anaesthesiology in some hospitals is not fully developed and needs reorganisation and augmentation. The efficiency of the team work in the operation theatre and post operative care depends on the chief anaesthetist. In some hospitals he is not actively associated with these functions.

Round the clock service, central supply of gass, central suction and adequate number of trained technical personnel, medical and para-medical, are not available.

The deficiency is particularly applicable to obstetric anaesthesia.

#### Obstetrics and Gynaecology

78. The maternity wards in all Delhi hospitals are over crowded. Domiciliary service based on hospitals is poorly organised. In Lady Hardinge Hospitals, however, a domiciliary service exists extending over 2 miles round the hospital.

The number of operation theatres attached to this Department are inadequate in some hospitals.

According to information given infection rate is high in all hospitals.

Facilities for blood transfusion in obstetric emergencies are not satisfactory.

Para-medical and ministerial staff are also not sufficient.

A system of confidential enquiry into maternal deaths hardly exists. The requires a searching examination into the medical history of the case to ascertain if any thing was done or left undone which might have



contributed to the fatal issue and, if so, to try to identify the factors which could be regarded as avoidable.

Operation theatres:

79. Considering the size of the hospitals and the different disciplines handled by them, the number of operation theatres is grossly inadequate in all hospitals, with the result that an operation theatre is shared by more than one speciality. Septic and clean surgery is handled in the same theatre. Eye, ENT and Gynaecology often share the same theatre. Most hospitals do not have a separate emergency theatre. The theatres are in use all the seven days of the week with no day off for cleaning. Operative work in disciplines like cardiothoracic and neuro-surgery, is done in common with surgery of septic cases. Modern equipment for anaesthesia, central supply of medical gases and central suction, supply of hot and cold sterile water and 100% positive pressure air conditioning, are not available in most hospitals.

Ultra-violet sterilisation does not exist in any of the hospitals.

Some theatres are centrally airconditioned, others have boom airconditioners and the remainder, no airconditioning at all.

The number of trained theatre technicians is inadequate. These that are available are frequently changed. There is no trained technical staff in theatres to look after costly instruments particularly the diagnostic endoscopic instruments. An instrument worth thousands of rupees is liable to be damaged by untrained workers.

Adequately equipped and staffed post-operative wards have yet to be established in most hospitals.

#### Central Sterilisation:

80. Some hospitals have still to organise a central sterilisation service. Safdarjang hospital is the only one where it is well organised.

Most of the personnel employed in certain central sterilisation departments are not trained. Proper supervision needs to be exercised.

Bacteriological sterility of the supplies of this department is not regularly checked to ensure proper quality. Quality control may be said to be non-existent.

### Casualty and Emergency Service

81. The development and organisation of the service in different hospitals have been variable. Some hospitals have an emergency ward attached to the department equipped to treat medical and surgical emergencies. Others have a receiving centre to admit patients to their respective wards. Casualty Medical Officers give round the clock service. Senior Post-graduate Registrars or Assistant specialists are not on duty to attend to patients admitted in the emergency ward in most of the hospitals. Some hospitals have a separate emergency theatre while in most the regular operation theatre is used for operative work on "emergencies".

The supporting diagnostic services of X-ray and laboratory are not available in some hospitals. Blood transfusion service is available in some hospitals only during the day time.

Casualty Departments also handle medico-legal cases. Attendance in courts by Casualty Medical Officers reduces the effective manpower in this department. In none of the hospitals can this service be claimed to meet the present day requirements of the Metropolitan area.

In none of the hospitals can the supporting ambulance service (also referred to earlier) be said to be satisfactory. Each hospital has one or at the most two vehicles. Even these are old. Most of the time they are off road. Sanctioned ambulance staff is not adequate to provide 24 hours cover. No record of incoming requests for ambulance is maintained by the control room telephone operator.

#### Special Disciplines

82. Efforts are being made to develop highly sophisticated medical disciplines like cardiovascular surgery neuro-surgery, genito-urinary surgery, plastic surgery etc. in all hospitals without well trained personnel- medical and para-medical-and without necessary sophisticated equipment. This is highly detrimental to the development of good and efficient health service.

These disciplines function in isolation without any functional integration with other hospitals. Quite a number of these units are not fit to serve the public efficiently and there is a great deal of frustration among the staff of such units.

#### Hospital Infection

83. The factors contributing to the problem of hospital infection and cross-infection, e.g.

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overcrowding in hospitals, uncontrolled traffic, insufficient attention to principles of hygiene and asepsis in the wards and operation theatres and unhygienic methods of dust removal, continue to exist in Delhi hospitals. As stated earlier, most of the hospitals do not have central sterilization system. In others, the old traditional system of sterilisation by boiling is in vogue. Where auto-claving is done for dressing, linen etc., regular quality control measures have not been adopted to check the efficiency of sterilisation. The personnel entrusted with the work of sterilisation is generally not qualified to handle this work.

The disciplines like cardiac-theracic surgery, neuro-surgery and plastic surgery etc. are being handled in a number of institutions in the same operation theatre where septic cases are dealt with simultaneously. As already pointed out the number of operation theatres is inadequate even for routine work. In some institutions, temporary or improvised arrangements are made which are not satisfactory.

Hospital infection and cross-infection exist all over the world. No scientific data is available from Delhi hospitals to determine the extent of the problem. However, the problem is real and alarming. Routine post-operative antibiotic cover exists in most hospitals and has resulted in

the emergence of drug resistant strains. It is distressing to note that in almost all institutions the magnitude of this problem continues to be ignored.

In certain institutions and departments, hospital infection and cross-infection are accepted as an inevitable part of hospitals treatment.

In certain areas, in particular in Paediatrics and obstetrics & Gynaecology, a substantial incidence of hospital infection is reported. Both the groups are highly vulnerable.

None of the hospitals have a Standing Committee for Prevention of Hospital Infection.

#### Medical Records.

84. In most hospitals the medical records are not properly maintained. In others an attempt is being made to organise this department for inpatients records. Safdarjang Hospital is following the system adopted in Vellore.

For outpatients, only the Orthopaedic Institute and Obstetrics department of Safdarjang Hospital maintain complete records; in Irwin hospital, the out-patients' tickets are retained.

In other out-patients, the patient is given the ticket to produce it at the next visit.

There is no modern photographic section with medical records section where it exists. Equipment of records department is practically lacking in all hospitals. The personnel in the records library are inadequate. Most of the hospitals do not have a statistician.

In one hospital X-ray photographs are tagged with patient's individual record to be destroyed along with it after 4-5 years. In other hospitals X-ray photographs are filed nowhere.

The working time of the record section is restricted to the office hours. It does not function for the major part of the day as a record library should. The information in the records is generally patchy, hardly suitable for any patient care evaluation or research work. The hospitals have not laid down the procedure for weeding out unnecessary documents or the period for which records are to be kept.

#### Medical Audit (Patient care evaluation)

85. Medical audit is not done regularly in any hospital. By this is meant the study of the quality of work produced by medical men, para-medical staff and nurses. Without medical audit

the standard of efficiency of hospital cannot rise. For example, in a given hospital there are two surgeons - Dr.A & Dr.B. Both of them have done 50 inguinal hernia operations in the age group 20-30 years. These were uncomplicated hernia cases. Dr. 'A's patients were discharged on the 5th day of the operation. Dr.'B's cases were discharged between 11th and 15th day of the operations. Medical audit department will immediately investigate Dr. 'B's cases and find out whether his patients had fever, whether they were given antibiotics etc. They will produce statistical data regarding the increased financial expenditure on his patients and the number of extra days, compared to A's cases, his patients occupied beds. The administration will now ask Dr. 'B' the reasons why his cases have gone septic, why he had used antibiotics, which is not normally necessary in hernia cases, and he will be severely warned that if this thing continues he will have to leave the hospital.

Such a system of medical audit on each person exists in American hospitals and that is why each member of the staff is on his toes to give his best.

#### Compulsory Autopsy

86. Side by side with medical audit if there is a provision for compulsory post-mortem, medical



men and their staff will be extremely careful in treating the patients. This will not function until and unless hospitals are prepared to do post-mortem within half an hour of the patients' death. Every hospital, will, therefore, have a staff to undertake this work as soon as the patient dies so that relatives of the patient do not have to wait.

#### Medico-legal

87. For medico-legal purpose Delhi is divided into three districts - Central, North and South. Such medico-legal cases, who do not require admission, are referred to Police hospitals after giving the preliminary treatment. For those who are admitted in the hospitals, the medico-legal report is completed by the Casualty Medical Officer and where required, by the treating medical officer in the ward.

No separate staff for medico-legal work is employed. The details of the time when police brought the patient, when he was examined and when he was admitted are not readily available.

Besides the Police Surgeon and his assistant, who perform post-mortems at the Tis Hazari mortuary, arrangements have also been made for conduction of medico-legal post-mortems at the Maulana Azad Medical College and the All-India

~~Institute of Medical Sciences.~~ Only the head of Forensic Medicine Department is authorised to perform such post-mortems. They undertake post-mortem cases from their respective hospitals. On Sundays and holidays when the Professors are not available, bodies are sent to the Police Surgeon for post-mortem. At present only four persons are authorised in Delhi to perform medico-legal post-mortems. The usual time lag between death and post mortem is 18-24 hours.

Between 1800 to 2000 medico-legal post-mortems are performed annually in Delhi of which about 60% pertain to Central Zone (Maulana Azad Medical College). Actually the Police Surgeon undertakes about 1100-1200 post-mortem a year and the Maulana Azad College and the All India Institute of Medical Sciences undertake about 300 cases each.

The two colleges will not be in a position to undertake more post-mortems unless other officers in those institutions are also authorised to conduct them.

Education and Training.

Medical  
Educa-  
tion.

88. Almost all major hospitals in Delhi participate in under-graduate and post-graduate medical education. All teaching hospitals are not adequately equipped and staffed to train a basic doctor. Too much emphasis is laid on specialities. This should be reserved for the post-graduate stage. The medical officers in some hospitals do not have the requisite experience and standing to be teachers.

89. For post-graduate training, the integrated system of training with practical experience in a particular speciality should be available to every post-graduate. In the teaching institutions in Delhi where post-graduate training is given, no emphasis is laid on training in the associated basic sciences.

The number of students admitted to every unit should be determined by the quality and quantity of resources available in the form of teaching staff, clinical material, supportive diagnostic services, physical facilities etc. and the nature of speciality. Thus, all hospitals in Delhi cannot have all disciplines in surgery and medicine for post-graduate training for the following reasons:-

a) The teaching personnel may have the qualifications but not the experience;

b) the number of patients attending that specialist service may not be enough for training the number of post-graduates in that discipline;

c) the associated disciplines connected with the particular speciality may not be developed in that institution to conduct post-graduate courses for the students.

d) equipment, laboratory and radiological services may not be fully developed in the institution for training the Post-graduate in the speciality that he has opted for, although there is a qualified specialist.

It is observed that some or all of the criteria referred to above are not being taken into consideration in allocating seats for post-graduate students in the Delhi hospitals.

Continuing  
Education

90. Continuing education of medical officers in service and general practitioners is essential for them to keep abreast with the modern trends in medicine. Not enough attention is being paid to organise these refresher and training courses for General Duty Medical Officers and practitioners who are the backbone of the medical care arrangements.

Positive  
Health and  
Health  
Education

91. The hospital continues to be a centre to give medical care to a patient for his disease or disability, without any consideration of the

family or the community to which he belongs. Very little in the way of health education and immunization is being practised at present in Delhi hospitals.

Training of Administrators

Entity dealing with diverse human and social

92. The modern hospital is no longer considered a place for keeping the sick and the injured only. It is a complex organic problems. The Medical Superintendent, Deputy Medical Superintendent and other officers engaged in hospital administration in most hospitals have had no formal training in this field. Hospital administration is a speciality by itself. As such, every medical officer cannot be expected to take up administration of hospitals without proper training and orientation in this speciality.

Training of Technicians.

93. Only in one or two institutions technicians are being trained in Delhi hospitals. In-service training and orientation courses are not being conducted. Recently, in the Safdarjang Hospital, a programme for training some categories of para-medical staff has been started. Lack of proper training and orientation has resulted in shortage of trained technicians with inevitable lowering of the efficiency of patient care.

Nurses' Training

94. Most of the hospitals have nurses' training schools. But the clinical facilities

available are not being utilised fully due to lack of residential and technical accommodation.

Centres for special disciplines like psychiatry, paediatrics, cardiology, cardio-thoracic surgery, neurology, neuro-surgery, plastic surgery etc. are being established more and more in the Delhi hospitals. They demand specialised nursing service. Facilities for training nurses in such disciplines are inadequate.

#### Staffing Pattern

95. It is observed that every general hospital has its individual staffing pattern and that there is no uniformity. Hospitals have during the years been adding more and more staff without any scientific evaluation or study of the workload. The same situation prevails in respect of para-medical, technical and non-technical staff. Besides service to patients, almost all hospitals participate either directly or indirectly in medical education. Some members of the medical staff in these hospitals do not have the requisite experience and standing to be independent teachers. Accordingly, full utilisation of the clinical material is not possible.

The creation of posts in certain disciplines in Super-time Grade I (Rs. 1800-2250) while keeping the posts of the parent departments of General Surgery and General Medicine in Super-time Grade II has created an anomalous situation in that the Professor of Medicine and Professor of Surgery are in the lower scale, while specialists in limited fields are in the higher scale. This anomaly has undermined the discipline and smooth working of the institutions.

In most hospitals there are no posts in Super-time Grade II, and where a post in Super-time Grade I exists in a particular branch, there is a wide gap between the senior officer in Super-time Grade I and the specialist.

#### Coordination

96. Because of the multiplicity of controlling authorities, no coordination exists among hospitals. This is so even among different institutions under the Ministry of Health. Growth of hospital services has been haphazard. There is hardly any organised group approach to the problems. A committee of Superintendents of Delhi hospitals has been in existence since 1963. However, its meetings have not been frequent or regular enough to be effective.

That services like Emergency and Accident Service, Blood Bank and Ambulance service are best organised at regional level, has not been sufficiently appreciated. The race to multiply specialities in several institutions without due regard to the needs of the area, availability of resources in qualified manpower, specialised equipment and funds continues unchecked because of the absence of any central coordinating agency.

### Planning

97. There is unequal distribution of beds in different sectors. The existing set up has been responsible for absence of overall planning, duplication of effort, and wastage of manpower and material resources. Each institution has been formulating its own plans without reference to the others.

Proper planning will reduce the cost of medical cars or at least control its rise in future, by ensuring economic utilisation of rare and costly medical resources. The need for planning cannot therefore be over-emphasized.



CHAPTER - 4CONCLUSIONS AND RECOMMENDATIONS4.1. Internal AdministrationOrganisation and AdministrationOrganisation:

98. In considering medical care organisation two questions arise:-

- (a) How effective are the present administrative arrangements?
  - (b) What changes are desirable in the organisation of medical staff in individual hospitals and also what contributions can clinicians make in the management and administrative arrangements of the hospital complex?
- to

Before an answer to the two questions is attempted it will be worthwhile to refer to the role of hospitals in the medical care programme. The suggestions made by the expert committee of the WHO in this connection are briefly summarised below:\*

"The hospital is an integral part of the socio-medical organisation the function

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\*Health Survey and Planning Committee  
Report page 81.

of which is to provide for the population complete health care both curative and preventive and whose out-patient services extend to the family in its own environment. The hospital is also a centre for the training of Health workers and for bio-social research. The modern hospital is thus a link between all aspects of the health art including the prevention of disease. Medico-social activities, public health administration and private practice carried out by medical practitioners in their consulting rooms all represent aspects of medicine which should be allowed to develop freely but which should also find in the general hospital, material support and close coordination. The general hospital should be a centre in which medical practitioners could find professional and intellectual aid, as its consultant services extend to the patients' home with the cooperation of the family doctor. The function of a modern hospital should be:

- (a) care of the sick and injured,
- (b) the education of the physicians, nurses and other personnel,

- (c) the promotion of health and prevention of disease,
- (d) advancement of research in scientific medicine, and
- (c) health education of the public."

The way in which the health services and the practice of medicine have developed has left the hospital with the most dramatic part to play in the care of the individual. The stay of a patient in hospital is only one event in the disease sequence. Hospitals at Delhi at present tend to work in isolation from other aspects of the community health service including the Central Government Health Service Scheme, a situation which clearly means inefficient utilization of costly hospital based resources.

The Committee considers that the medical care in the Central Government Health Scheme, in which the hospital care is also integrated, should be considered as a single entity. Although medical care is provided in the home, in the clinic or dispensary and the hospital, there is no integration of these services at present. The hospital section which is the most costly element in the CGHS should function as an integral part of the entire scheme rather than as a separate service.

99. In the individual hospitals internal

cooperation and coordination which are essential have not developed commensurate with their growth. The shortcomings of the existing organisation are lack of understanding of the group responsibility of administrator, nursing services and clinicians towards hospital management; inadequate use of resources; improper training; lack of cooperation between specialities; absence of patient care evaluation; and lack of proper hospital designs.

100. The management of the hospital is not the sole prerogative or responsibility of the medical superintendent. It is, and must remain, a collective responsibility of the administrator and the clinician. In other words, management of the hospital must be broad based. The Committee suggests that the pattern of reorganisation should be such that it gives opportunity for planned use of resources; ensures coordination with other specialities and services; facilitates evaluation of hospital work by the participating staff; and encourages education and research in the hospital. As patient care must get priority over other considerations, administration must be moulded to suit clinical and allied activities.

101. Broadly speaking the hospital activities can be divided into administrative and clinical. The primary aim of both is efficient patient care.

102. The administrative structure of the hospital should be tripartite as follows:-

- (a) medical administration;
- (b) nursing administration;
- (c) lay or business administration.

Competent and fully trained people should be in charge of these functions. This tripartite partnership is very important. The Superintendent of the hospital should meet the nursing administrator and the lay administrator periodically to coordinate the day to day administration of the hospital. The Medical Superintendent's success and the efficiency of the hospital depend upon his ability to integrate the administrative and clinical activities.

Much of the work which is of non-medical nature, which falls properly in the domain of the lay administrator, is being done by the doctors and nurses in the hospitals. They should be relieved of these duties, as early as possible, to improve the efficiency of patients care. Demarcation of the duties between the medical, nursing and lay administration should be clearly defined.

103. The heads of different clinical divisions should be actively associated in the day to day administration of the hospital. This can only be achieved by creating an executive committee

comprised of clinicians and administrators to discuss and formulate major policies.

For this purpose the specialities in each hospital should be grouped into divisions. The senior most officer in each division should be made the Chairman and be responsible for the management of his division. He should carry out constant appraisal of the services his division provides, deploy clinical resources as effectively as possible and cope with the problems that arise in the clinical field.

The Chairmen of all the divisions should form the executive committee of which the medical superintendent should be the convenor. The functions of the executive committee would be to receive divisional reports, to consider major medical policies and planning and to coordinate administrative and clinical activities.

#### Administration

104. The Medical Superintendent, preoccupied with clinical and teaching responsibilities, has not been able to devote enough attention to hospital administration. This has been the main cause of weakness in hospital administration in Delhi. The Committee is convinced that the medical superintendent should be a full-time appointment and that the

incumbent chosen for this appointment should be a senior doctor with experience of hospital administration. A full team of experienced administrative staff should be made available to each of these hospitals. The suggested organisation of administrative set up is given in Annexure.

#### Standing orders

105. The Committee recommends that each hospital should prepare a complete set of standing orders clearly defining the duties of the various members of the staff and laying down orders in respect of activities of the hospital. The Dy. Medical Superintendent and other administrative staff should ensure that standing orders are actually implemented and ~~kept up-to-date~~. Suggested headings for the standing orders may be seen in Annexure

#### Standing Committee

106. From out of the hospital administrative staff a Standing Committee should be established for the purpose of auditing accounts, stock verification, condemnation board, personnel management and so on. Each hospital should organise day to day auditing and introduce various audit checkes to ensure correct accounting and prevent pilferage and avoidable waste.

#### Medical Stores and Equipment

107. Direct supervision of the medical stores should be at officer level. Accommodation

(including cold storage and shelves) should be brought up to scale. Store Keepers employed in medical stores should be given adequate training in the maintenance of proper accounts. A very practical method of storage is on the basis of sections in the vocabulary of medical stores. Surprise as well as other periodical checks of stores should be carried out regularly and the results of checks recorded.

Indents for medical stores should show the pharmacopeial names of drugs required. Proprietary names should as far as possible be avoided. It is felt that this measure alone will effect considerable economy in the drugs bill of these hospitals. Where it is not possible to avoid proprietary names, it would be worthwhile bracketting together more than one such preparation having the same therapeutic action in order to introduce limited scope for competition in the market. The National Formulary should be taken to greater use for the above purpose.

Central  
Purchase  
Organisation

108. The Medical Store Depot at Karnal has not been able to meet the demands of these large hospitals in Delhi. As this depot functions on a commercial basis, if hospitals resort to direct procurement, a certain amount of economy can be effected. For this purpose it is necessary



to create an organisation common to all the hospitals. It is understood that sometime back a proposal was submitted for establishing a Non-Store Holding Central Purchase Organisation for all hospitals in Delhi to coordinate the demands from these hospitals, to institute rate enquiries and to establish rate contracts. Such a central purchase organisation will have the added advantage of being able to bulk together small demands from individual hospitals for major items of equipment in order to attract competitive offers from suppliers.

The Central Purchase Organisation should encourage placement of demands for larger packing of pills, tablets, capsules, ointments etc. to reduce the cost.

They should also issue policy directives on indenting, stocking, accounting, stock verification, write off of losses, accounting of short life items and stores preservation.

Standardization 109. Standardisation of scales of equipment for hospitals of various sizes is absolutely essential. In the absence of such scales, equipment and stores are likely to be procured depending on the individual whims and fancies of the officers placing the demands for the same. As individuals change, new types of equipment and stores are acquired and the old ones accumulate. If scales of equipment are laid down, no hospital will be in a position to hold

surplus. Stock verification will also become more meaningful, in that the verifying officer will be able to ensure that the stocks held are according to authorised scales. Special requirements of specialist departments can be met by preparing separate scales of equipment for them. As leading specialists will be associated with the preparation of such scales, they will be able to ensure that the scales provide all their requirements. The preparation and periodical review of these scales can be entrusted to the Central Stores Purchase Organisation. This organisation will coopt specialists required for consideration of each scale.

Quality  
Control

~~109.~~ 110. An effective organisation for quality control of drugs supplied to these hospitals has to be established. Restriction of purchases to preparations of reputable firms necessarily means more expenditure on drugs.

(a) A hospital pharmaceutical service should be started in one of the hospitals as a pilot project. This service should be in the charge of a Chief Hospital Pharmacist who should be at least a post-graduate in pharmacy having experience in manufacturing crystalloids and other parenteral preparations. The hospital pharmaceutical service will have a central distribution service section, a manufacturing section and an analytical chemist section. The first will be responsible to

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distribute preparations to wards and departments, the second for manufacturing crystalloids and other preparations and the third for exercising quality control over products including those received from the market. It is understood that the economics of such a project have been worked out. On the basis of experience gained from the pilot project establishment of similar pharmaceutical service on a regional basis can be considered, if necessary.

(b) Until the above recommendation for strict quality control is implemented, it will be necessary to ensure that tenders are accepted only from those firms whose quality control measures have been inspected and found satisfactory.

Supervision  
and Staffing  
of Stores

111. There are many attractive items of stores in a hospital like linen, blankets, costly drugs, gift articles, utensils, crockery, cutlery, rations and so on. Unless effective measures are adopted to exercise direct and frequent indirect supervision over the accounting of these stores, pilferage cannot be avoided. The employment of trained and experienced Stores Officers and Store Keepers will pay high dividends in the long run.

Central Work  
shop Facilities

112. The possibility of establishing a central repair/service/maintenance workshop for major items of equipment should be explored. The existing

workshop of All India Institute of Medical Sciences with suitable augmentation can fulfil this function for all hospitals in Delhi. While one Central Workshop would do for this purpose for all hospitals in Delhi, a few tradesmen like mechanic, carpenter, electrician should be authorised to each hospital to attend to day to day repairs and maintenance of hospital equipment and stores.

Alternative sources of Water Supply & Electricity

113. To meet breakdowns which are frequent. the Committee recommends that every hospital should have alternative sources of electricity and water-supply which should come into play automatically on the failure of the normal sources. The mere provision of a generator for the operation theatre and the emergency and accident service is not enough. Alternative source of lighting should also be available in other places e.g., labour room, blood bank, busy corridors and lifts. The alternative source of water supply should be connected to the main water reservoir. These alternative services should be tested periodically to ensure that they are in the working order.

Sanitation

114. The Committee finds that the general cleanliness has been neglected. The hospital matron does not appear to be able to play an active role in the maintenance of proper

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sanitation in operation theatres and wards. A concerted drive to improve general sanitation is essential. Incinerators must be built and used particularly to dispose of soiled dressings and other infected materials, dead tissues removed from the bodies of patients viz., amputated limbs; placentas in maternity department, instead of throwing them into the public receptacles. Each hospital should have a sanitary squad under a sanitary inspector to ensure proper upkeep.

Unauthorized structures for habitation should in no circumstances be permitted in the hospital campus as has happened in the case of the Lady Hardinge Medical College and Hospital.

Kitchen and Diet

115. The dietary department in most of the hospitals needs reorganisation on sound scientific lines. The cost on diet in different hospitals varies. Every patient in the ward should get diet according to his need. To ensure a "need based" balanced diet, the Committee recommends that hospital diets for all hospitals in Delhi should be standardised.

115. The deficiencies of dieticians in various hospitals should be made good.

Sanitary conditions of the kitchens must receive adequate attention. Sanitary rules for the kitchen should be displayed and periodical checks carried out to ensure that these rules are implemented. A strict watch should be

vaccination state of the staff working in the kitchen.

Gas is considered the most suitable fuel for cooking in hospitals.

The quality and quantity of articles of rations, both fresh and dry, should be checked by the Store Officer and accounted for by him. Only quantities for daily consumption should be issued to the kitchens. Accounting of quantities thus issued should be the responsibility of the steward/dietician. Periodical laboratory tests of samples of milk drawn from the kitchen and wards should be carried out to eliminate adulteration and records of such tests maintained. Food should be sent to wards in thermostatic food trolleys with locks. Cold storage facilities for dairy products, meat fish and eggs, and fresh vegetables and fruits, is a must in the hot weather of Delhi. These do not exist in any hospital with the result that the hospitals do not hold any stocks of these commodities for more than a few hours. Physical facilities in the form of ration stores including cold storage, hot case, furniture, food trolleys and distribution counter should be brought up to scale. Reserve stock of rations should be maintained to meet emergencies.

Willingden Hospital: Ordinary food trolleys should be replaced by thermostatic trolleys with locks. Periodic health check of kitchen staff should be

carried out and the results recorded on a permanent register.

Safdarjang Hospital: One dietician for an institution with about 1200 beds cannot look after the normal and special diets. The sanctioned posts of two more dieticians should be filled.

Lady Harding Hospital: The physical facilities in respect of accommodation, storage, refrigeration and cooking aids do not at all meet the requirements of a modern kitchen. The existing set up requires to be replaced by a clean, hygienic kitchen with adequate storage space including cold storage. Thermostatic Food trolleys with locks should be provided. Record of periodical health check up of kitchen staff should be maintained.

Irwin Hospital: Cold storage facilities should be provided. For despatch of food to wards thermostatic food trolleys with locks should be provided. Regular periodic check of health state of kitchen staff should be carried out and recorded.

Hindu Rao Hospital: The hospital should have at least one dietician. The kitchen should be modernised.

Laundry:

116. The Committee recommends that mechanical laundry service should be available to all hospitals. Mechanical laundries where provided are not properly organised to ensure thorough

segregation of soiled linen from washed linen. Separate incoming and outgoing counters should be arranged.

In the planning of laundry expert advice should be taken.

The idle capacity of mechanical laundries wherever installed should be fully utilised. Arrangements should be made for adequate supply of steam to the laundry in the Irwin Hospital and it should be adequately staffed to undertake the work of this hospital as well as the G.B. Pant Hospital. Similarly the laundry under installation at Willingdon Hospital should undertake the work of both the Willingdon and the Lady Hardinge Hospitals.

Mattress sterilizers must be provided. Blankets should be chemically sterilised. This will reduce cross infection in wards.

#### Linen.

117. The Committee is of the view that linen for all hospitals should be standardised. Khadi linen should be replaced with mill cloth as the former collects dirt easily and leads to infection.

#### Transport facilities.

##### (1) Ambulance:

118. The existing ambulance services are not satisfactory. The 102 control room is not adequate and has to be reorganised. The ambulance service should be centralised.



Large ambulance cars are unmanageable and unnecessary for the use within the hospital. Each hospital should have two or three small ambulance cars for internal use. The Committee feels that this service can better be provided by pooling all the large ambulances together under a central authority with a Central control room for Emergency Service referred to later.

(ii) For transport of stores every hospital should have a minimum of one or two load carrying vehicles.

The Committee recommends that repairs and maintenance facilities for these ambulance cars and other mechanical vehicles should be organised centrally. For this purpose the central authority holding the vehicles could have a small complement of workshop personnel and equipment to carry out inspection, maintenance and minor repairs. Major repairs can be referred to private workshops on contract basis until the Central vehicle depot with workshop complement is established.

The present arrangements for the repair and maintenance of hospital buildings, furniture and fittings are not satisfactory as the hospital authorities have to contact different sections of the CPWD to deal with different types of work and the service thus obtained is not always prompt. Large hospitals have enough maintenance work to justify full time engineering staff. For this purpose the

Committee recommends that the maintenance engineering staff should be placed under the control of the medical superintendent of the hospital.

#### Public Relations/Amenities

##### Reception and Enquiry

118.A. The Committee suggests that each hospital should have a central reception and enquiry located at a prominent place available both to outpatients and inpatients. As the outpatients department is the normal portal of entry to a hospital, it is better located there in close proximity to the Emergency and accident service.

The reception and enquiry should provide round the clock service and be staffed with experienced and competent personnel including social workers. They should have all information pertaining to the hospital services preferably in a booklet with a guide map showing the location of different departments. Complete information of daily admissions and discharges and condition of seriously ill patients should be readily available. They should be provided with good communication facilities, internal as well as external.

##### Welfare of patients

Adequate recreational facilities should be provided for patients in hospital. The services of social workers should be available to help patients with their personal problems. The introduction of a complaints/suggestions book for the use of patients and visitors may, perhaps, lead to abuse in such busy hospitals. However, it is essential that every patient is seen by a medical officer every day. Apart from enquiry about his physical ailments, the medical officer should also listen to any other

complaint or suggestion that his patients may have to make and take suitable remedial action. Social worker will be able to assist the medical officers to a great extent in this respect. The patients should also be interviewed by the head of the unit or his assistant at the time of their discharge to ensure that they are satisfied in every respect. A medical officer should also be available in the ward or group of wards during visiting hours to answer the anxious enquiries of friends and relations.

#### Sign Posting

Sign posting in hospitals should be prominent, simple and intelligible to the common man. Night signs should be provided.

#### Horticulture

Horticulture should receive greater attention. Manis should be transferred to the establishment of the hospital and come under the control of the Medical Superintendent.

Provision should be made in all hospitals for cycle stands and car parks. The security of these should be ensured. There should be separate weather proof cycle stands and garages for the hospital staff.

Each hospital should also provide the amenities of:-

- (a) Dharmshalla for use of relatives of patients coming from distant places on nominal rent.
- (b) A canteen to provide snacks to visitors who are held up at the hospital.

Some control has to be exercised on visitors to the hospital. It is appreciated that occasions do arise for visitors to come to the hospital even outside visiting hours but a check has to be maintained.

to reduce such visits to the minimum.  
 Visiting hours should be more strictly observed.  
 It is realised that it is difficult problem and  
 that will need considerable propaganda and  
 effort at public education to get the co-operation  
 of the public. Visitors should not be allowed  
 to sit on the hospital beds of patients.

Willington Hospital: A central admission office  
 should be organised as a part of central  
 reception and enquiry which should function  
 round the clock and maintain full information  
 regarding admissions, discharges, and seriously  
 ill-patients. Dharamshala for over-night stay  
 of visitors should be provided. Canteen  
 facilities should be organised.

Safdarjung Hospital: For guidance of patients  
 attending different out-patients, facilities  
 should be provided at the central registry of  
 admission. A canteen and facilities for stay  
 of visitors are also required.

Lady Hardinge Hospital: A proper reception and  
 enquiry should be organised. Dharamshala and  
 canteen should be provided.

Irwin Hospital: Central reception and enquiry  
 is to be strengthened with additional staff  
 including social workers.

Hindu Rao Hospital: Reception and enquiry should be completely reorganised.

119. Welfare and Discipline of Staff

Maintenance of discipline in the hospital is an important aspect of medical administration. It has to be at all levels, right from top administrator to the medical auxiliary at the service end. The Hospital is a complex organic entity. Laxity or indifference on the part of any of the services can put the function of the hospital completely out of gear. It is in this context that the question of discipline and attitude of the hospital staff has to be approached. For some time past there has been a growing tendency on the part of medical officers to resort to measures which would dislocate the working of health services. There has been a long drawn out dispute between the Ministry of Health and the medical officers regarding their service conditions. This has to date not been smoothened. Housemen struck work for betterment of their working conditions. C.G.H.S. doctors went on a day's token strike followed by slow work protest on the promulgation of the terms of the Central Health Service. Nurses also proposed to join this race. Discipline, loyalty and service to the society are at a low ebb.

The unrest in the country and the world over has had its repercussions also on the hospital staff. The uncertainty whether the action of the hospital administrator will be upheld by the higher authorities makes him take the line of least resistance. Lapses of the staff continue to be ignored. Disregard of Government servants' Conduct Rules is reported. Doctors and other staff for their personal advancement are reported to utilize all types of influences including political. This undermines discipline of the institution and the services. The person at the decision making level feels demoralised.

It is for consultants and senior officers to correct their housemen in clinical matters and set an example to them. The discipline of senior medical staff poses a very difficult problem. Lack of team spirit and mutual misgivings among them, in the Committee's view, have contributed to the lowering of the efficiency and quality of medical care. The tendency of the Medical Superintendent to keep the senior clinical staff out of the hospital administration has further widened the gulf between them.

A further factor which has aggravated the situation is that with the adding of new services and increase of beds, the hospital staff is not

The Committee notes that certain deficiencies in the hospitals are not due to any fault of the staff but due to the financial and social circumstances. The lack of suitable residential accommodation, the increasing pressure due to the rising demands of the people and the frequent criticism by the public who fail to appreciate their difficulties have all contributed to the lowering of the morale of the hospital staff.

The Committee considers that the approach to the problem of growing indiscipline has to be viewed from a constructive and humane angle. Working conditions, particularly of the lower staff, are far from satisfactory. Housemen and Registrars, the backbone of clinical service, do not have proper living conditions.

The Hospital staff functions in water-tight compartments and not as members of a family. Mutual adjustments will develop if there is a free exchange of views. Absence of counselling leads to misgiving. In the function of the hospital all persons should be made to feel that they contribute to the running of the institutions.

DISCIPLINE, LOYALTY TO THE INSTITUTION AND SERVICE TO MAKING AND HUMANITARIAN APPROACH SHOULD BE THE WATCHWORD FOR ALL WORKERS OF ALL CATEGORIES IN HOSPITALS. IN THIS CONNECTION THE QUOTATION OF CHARAKA SAMHITA AND HIPPOCRATES ARE GIVEN BELOW.

"NOT FOR SELF.

NOT FOR THE FULFILMENT OF ANY EARTHLY DESIRE  
OF GAIN, BUT SOLELY FOR THE GOOD OF SUFFERING  
HUMANITY, SHOULD YOU TREAT YOUR PATIENTS AND SO  
EXCEL ALL. THOSE WHO SELL THE TREATMENT OF  
DISEASES AS MERCHANDISE, GATHER THE DUST AND  
NEGLECT THE COLD"

CHARAKA SAMHITA, CHIKITSA STHANAM 1:4:59 (1,000 BC).

WHERE THERE IS LOVE OF MAN

THERE IS ALSO LOVE OF ART.

"The Physician, who is also philosopher, is  
like unto the gods. There is no great  
difference between medicine and philosophy,  
because all the qualities of a good philosopher  
should also be found in the physician: impar-  
tiality, zeal, modesty, dignity of appearance,  
seriousness, tranquil judgement, serenity of  
decision, purity of living, knowledge of  
what is useful and necessary, rejection of  
all that is wicked, a soul free from suspicion  
and devotion to the divinity. Where there is  
love of man there is also love of art."

Hippocrates

As referred to in the earlier part of this  
report, the Committee recommends that the medical  
superintendent should associate the clinical and  
administrative staff at appropriate levels in  
decision making and hold regular periodic meetings  
and conferences among them.



The Committee is, however, of the view that the hospitals should be removed from the purview of the Industrial Disputes Act for the sake of patient care.

### Hospital Costing

120. In the absence of any set plan for the booking of hospital expenditure, it is well nigh impossible to attempt any comparative study of the hospital services in Delhi and to indicate the department or service where expenditure is excessive and susceptible to reduction. As a first step to understand the financing of these hospitals, the Committee suggests that a simple uniform system of hospital cost accounting based on the subjective headings of the financial accounts be introduced. The details of items to be booked under different sub-heads should be clearly laid down for the guidance of the hospitals. It is also desirable to organise later a system of departmental and unit costing of the services. This would be of value to hospital administration and would facilitate efficient and economic spending. A system of hospital costing which should be simple but at the same time enough informative to bring out the costs of salient hospital activities be adopted.

The Committee considers:

THAT THE HOSPITAL SHOULD FUNCTION AS AN INTEGRAL PART OF THE ALL COMPREHENSIVE HEALTH SERVICE BOTH CURATIVE AND PREVENTIVE.

The Committee recommends:

(1) THAT THE ADMINISTRATION OF AN INDIVIDUAL HOSPITAL CALLS FOR A GROUP RESPONSIBILITY AND COLLECTIVE THINKING BY DIVISIONAL HEADS OF DIFFERENT CLINICAL DISCIPLINES.

(2) THAT THE OFFICE OF THE MEDICAL SUPERINTENDENT SHOULD BE A FULL-TIME APPOINTMENT WITH NO CLINICAL RESPONSIBILITIES AND THE INCUMBENT SHOULD BE A SENIOR MEDICAL OFFICER WITH POSTGRADUATE QUALIFICATIONS AND WITH EXPERIENCE OF HOSPITAL ADMINISTRATION.

(3) THAT THE ADMINISTRATIVE STRUCTURE OF THE HOSPITAL SHOULD BE TRIPARTITE:

- a) CLINICAL,
- b) NURSING, &
- c) LAY OR BUSINESS ADMINISTRATION,

(4) THAT IN EACH HOSPITAL DIFFERENT SPECIALISTIES SHOULD CONSTITUTE DIVISIONS WITH THE SENIOR MOST

PERSON AS CHAIRMAN. EACH DIVISION SHOULD CARRY OUT CONSTANT APPRAISAL OF THE SERVICES IT PROVIDES, DEPLOY CLINICAL RESOURCES AS EFFECTIVELY AS POSSIBLE AND COPE WITH THE PROBLEMS THAT ARISE IN THE CLINICAL FIELD.

(5) THAT THE CHAIRMEN OF DIFFERENT DIVISIONS .e.g., MEDICINE AND ALLIED SPECIALITIES, SURGERY & ALLIED SPECIALITIES, OBS. & GYN&EC. AND ALLIED DISCIPLINES INCLUDING FAMILY PLANNING: PEDIATRICS AND CHILD HEALTH: RADIOLOGY & RADIO-THERAPY: LABORATORY SERVICES ETC., WITH THE MEDICAL SUPERINTENDENT OF THE HOSPITAL AS CONVENCOR, WILL FORM AN EXECUTIVE COMMITTEE. THE FUNCTIONS OF THIS COMMITTEE WILL BE TO RECEIVE DIVISIONAL REPORTS, TO CONSIDER MAJOR POLICIES AND PLANNING AND TO COORDINATE HOSPITAL CLINICAL ACTIVITIES.

(6) THAT STANDING COMMITTEES SHOULD BE ESTABLISHED FOR PURPOSES OF AUDITING ACCOUNTS, STOCK VERIFICATION, CONDEMNATION BOARDS ETC.

(7) THAT EVERY HOSPITAL SHOULD PREPARE COMPLETE SET OF STANDING ORDERS DEFINING THE DUTIES & POWERS OF MEMBERS OF HOSPITAL STAFF.

8. THAT TRAINED STORE KEEPERS SHOULD HANDLE HOSPITAL STORES AND WORK UNDER THE DIRECT SUPERVISION OF A SENIOR OFFICER.
9. THAT ADEQUATE ACCOMMODATION (COLD STORAGE & SHELVES) SHOULD BE PROVIDED FOR DIFFERENT STORES.
10. THAT HOSPITALS SHOULD ADOPT THE NATIONAL FORMULARY. DRUGS SHOULD BE INDENTED BY PHARMACEUTICAL NAMES. PROCUREMENT BY BRAND AND PROPRIATORY NAMES SHOULD BE RESORTED TO ONLY IN EXCEPTIONAL CIRCUMSTANCES.
11. THAT EACH HOSPITAL SHOULD HAVE A DRUGS COMMITTEE.
12. THAT AN ORGANISATION FOR QUALITY CONTROL OF DRUGS SUPPLIED TO HOSPITALS SHOULD BE ESTABLISHED.
13. THAT STANDARDIZATION OF EQUIPMENT AND STORES IS ESSENTIAL FOR HOSPITALS. SCALES OF EQUIPMENTS WITH SPECIFICATIONS FOR DIFFERENT HOSPITAL UNITS SHOULD BE LAID DOWN.
14. THAT EACH LARGE HOSPITAL SHOULD DEVELOP PHARMACY SERVICE TO UNDERTAKE, UNDER PROPER ASEPTIC CONDITIONS PREPARATION OF INTRAVENOUS AND OTHER FLUIDS REQUIRED FOR THE HOSPITAL

USE, THIS SHOULD BE LOCATED ALONG WITH  
THE CENTRAL STERILISATION TO MAKE IT  
ECONOMICAL.

(15) THAT A CENTRAL UNIT FOR ALL HOSPITALS  
SHOULD NEGOTIATE RATE CONTRACTS WITH  
SUPPLIERS, FOR SUPPLY OF DRUGS, DRESSINGS,  
INSTRUMENTS, APPLIANCES, HOSPITAL  
EQUIPMENT, FURNITURE, LINEN, ETC. AGAINST  
WHICH HOSPITAL AUTHORITIES ORDER AND  
THEMSELVES PAY FOR WHAT THEY REQUIRE.

(16) THAT A CENTRAL WORKSHOP FOR MAINTENANCE  
AND REPAIR OF HOSPITAL EQUIPMENT SHOULD  
BE ESTABLISHED.

(17) THAT THE MAINTENANCE ENGINEERING STAFF  
IN THE HOSPITAL SHOULD BE PLACED UNDER  
THE MEDICAL SUPERINTENDENTS.

(18) THAT TO ENSURE UNINTERRUPTED SUPPLY OF  
WATER AND ELECTRICITY DURING BREAKDOWN  
OF THESE SERVICES, EVERY HOSPITAL SHOULD  
HAVE ARRANGEMENTS FOR ALTERNATIVE SOURCE  
OF WATER SUPPLY & ELECTRICITY.

(19) THAT EACH HOSPITAL SHOULD HAVE A SANITARY  
SQUAD TO ENSURE PROPER UPKEEP.

(20) THAT DEAD TISSUES, SOILED DRESSINGS,  
AMPUTATED LIMBS ETC. SHOULD BE DISPOSED  
OFF BY INCINERATION AND THE GAS UTILISED

AS POWER FOR THE HOSPITAL.

- (21) THAT UNAUTHORISED QUARTERS SHOULD NOT BE ALLOWED TO BE PUT UP IN HOSPITALS. THE EVICTION OF UNAUTHORIZED HUTMENT DWELLERS IN THE COMPOUND OF LADY HARDINGE SHOULD BE CARRIED OUT IMMEDIATELY.
- (22) THAT DIETS FOR ALL HOSPITALS SHOULD BE STANDARDIZED.
- (23) THAT PROPER CHECKS ON THE QUALITY AND QUANTITY OF STORES RECEIVED SHOULD BE EXERCISED BY THE STORE OFFICER AND ACCOUNTED FOR BY HIM. THAT EVERY HOSPITAL SHOULD HOLD A RESERVE STOCK OF RATIONS FOR EMERGENCY.
- (24) THAT SEPARATE COLD STORAGE ACCOMMODATION FOR DAIRY PRODUCTS FRESH FRUIT AND VEGETABLES, AND MEAT AND EGGS, BE PROVIDED IN THE HOSPITAL KITCHEN.
- (25) THAT FOOD SHOULD BE DESPATCHED TO WARDS IN PROPER THERMO-STATIC TROLLEYS WITH ARRANGEMENTS FOR LOCKING.
- (26) THAT ADEQUATE NUMBER OF DIETICIANS SHOULD BE APPOINTED IN EACH HOSPITAL.
- (27) THAT THE DIETICIAN SHOULD SUPERVISE THE GENERAL AND SPECIAL DIET KITCHENS.
- (28) THAT THE SIX MONTHLY HEALTH CHECK UP OF FOOD HANDLERS AND OTHERS WORKING

IN THE KITCHEN SHOULD BE STRICTLY ENFORCED  
AND RECORDS MAINTAINED.

- (29) THAT THE DEFICIENCIES IN THE KITCHENS  
OF INDIVIDUAL HOSPITALS MENTIONED ABOVE,  
BE ATTENDED TO EXPEDITIOUSLY.
- (30) THAT COOKING BY GAS BE PROVIDED WHEREVER  
IT DOES NOT EXIST.
- (31) THAT FOR WASHING OF LINEN, HOSPITALS  
SHOULD MAKE USE OF MECHANICAL LAUNDRY.  
THE INSTALLED CAPACITY OF HOSPITAL  
LAUNDRIES SHOULD BE FULLY UTILISED.  
THE WORK FROM MORE THAN ONE HOSPITAL  
COULD BE POOLED.
- (32) THAT MATTRESSES STERILIZER SHOULD BE  
HOUSED IN THE BUILDING WHERE LAUNDRY  
IS LOCATED.
- (33) THAT THE HOSPITAL LINEN SHOULD BE  
STANDARDIZED. KHADI SHEETS BE REPLACED  
BY MILL CLOTH AS IT IS DIFFICULT TO  
KEEP THEM CLEAN & FREE OF INFECTION.
- (34) THAT HOSPITALS SHOULD ENSURE ROAD  
WORTHINESS OF AMBULANCES AND OTHER  
VEHICLES.
- (35) THAT ALL HOSPITALS SHOULD HAVE A  
CENTRAL RECEPTION AND ENQUIRY FOR  
INPATIENTS IN THE EMERGENCY DEPARTMENT

PROVIDING ROUND THE CLOCK SERVICE.  
 INFORMATION OF DAILY ADMISSIONS AND  
 DISCHARGES AND DEATHS, SERIOUSLY OR  
 DANGEROUSLY ILL PATIENTS SHOULD BE  
 READILY AVAILABLE.

(36) THAT EVERY HOSPITAL SHOULD HAVE A BOOKLET  
 GIVING ESSENTIAL INFORMATION FOR THE  
 GUIDANCE OF PATIENTS.

(37) THAT PROPER SIGN POSTING INCLUDING NIGHT  
 SIGNS AND DIRECTION POINTS BE PROVIDED TO  
 ENABLE PATIENTS AND VISITORS TO REACH  
 THE APPROPRIATE DEPARTMENT.

(38) THAT FOR THE SERIOUSLY ILL PATIENTS  
 PERMISSION SHOULD BE GIVEN FOR RELATIONS  
 TO STAY NEARBY. सत्यमेव जयते

(39) THAT DHARMSALA TYPE FACILITIES FOR STAY  
 OF VISITORS FROM OUTSTATIONS BE PROVIDED  
 NEAR HOSPITALS.

(40) THAT CANTEEN FACILITIES FOR VISITORS  
 BE PROVIDED.

(41) THAT THE GOVERNMENT SHOULD TAKE EARLY  
 STEPS TO AMEND THE INDUSTRIAL DISPUTES  
 ACT SO THAT ITS PROVISIONS SHOULD NOT  
 APPLY TO HOSPITALS, TEACHING INSTITUTIONS,  
 DOCTORS, NURSES AND OTHER HOSPITAL WORKERS

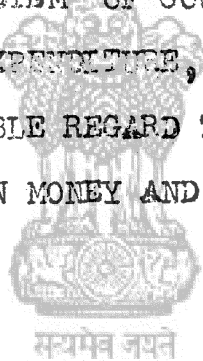
THE GOVERNMENT SHOULD TAKE EARLY



STEPS TO CONSTITUTE MACHINERY TO RESOLVE  
GENUINE GRIEVANCES OF THOSE WORKING IN  
THE HOSPITALS,

(43) THAT IN THE INTEREST OF THE DOCTORS AS  
WELL AS ADMINISTRATION ANY LAPSES IN  
THE ATTENTION TO PATIENTS SHOULD  
BE GONE INTO IMMEDIATELY BY AN APPROPRIATE  
BODY.

(44) THAT A COMMITTEE BE SET UP TO DEVISE  
A SUITABLE SYSTEM OF COST ACCOUNTING  
OF HOSPITAL EXPENDITURE, WITH THE  
FULLEST POSSIBLE REGARD TO THE NEED  
FOR ECONOMY IN MONEY AND MANPOWER.



## LABORATORY SERVICES

121. The hospitals in Delhi can be broadly classified in two categories:

(a) Hospitals like the Willingdon, the Safdarjang, the Hindi Rao and the Govind Ballabh Pant, whose primary duty so far is "Patient care" but who also undertake training of varying numbers of postgraduates in different Specialities.

(b) Institutions like the A.I.I.M.S., Maulana Azad and the Lady Hardinge, which are primarily teaching Institutions with well organised Departments of Pathology, Microbiology and Biochemistry.

The pattern of organisation of laboratory services in these two types of Institutions has been distinctive. However, "Clinical Pathology" has been neglected in both these categories of hospitals. In the first, there has been no planned programme of development of clinical laboratory services.

One would like to emphasise that the word "Clinical Pathology" has lost its real connotation. Under its broad heading are included Clinical Haematology, including Blood Bank Service, Clinical Microbiology including Parasitology, Virology and Immuncology, Morbid Anatomy including Histology and Autopsy service and Clinical or Chemical Pathology (Biochemistry).

Under the existing set up, these Departments seem to occupy un-attractive and inadequate hospital space. There is no schedule of the

staffing pattern, both for the technical and non-technical personnel and the administration in general seems to patronise their existence without giving much thought to their requirements. There has been no planned or effective development of Specialities like Clinical Bacteriology, Clinical Haematology, Biochemistry and Morbid Anatomy with the result that in many of the hospitals, they have neither the trained technical staff nor the efficiency to perform their manifold duties. It is thus necessary to ensure that such hospitals have a complement of staff which will undertake efficiently the investigations relating to the hospital patients.

As is being recommended by this Committee, it would be extremely desirable to integrate the Willingdon Hospital with the Lady Hardinge Medical College functionally, the AIIMS with the Safdarjang Hospital and the Govind Ballabh Pant with Maulana Azad Medical College. The Hindu Rao Hospital should continue to remain a non-teaching hospital. However, the immediate need is to upgrade the quality of different laboratory services in the Willingdon, the Safdarjang, the Gobind Ballabh Pant, the Irwin and the Hindu Rao Hospitals.

The Committee recommends:

(45) THAT NO SEPARATE SECTIONS OF MORBID ANATOMY BE STARTED IN THESE HOSPITALS. THE AUTOPSY AND MORBID ANATOMY SERVICE OF THESE HOSPITALS BE TAKEN OVER BY THE RESPECTIVE INSTITUTIONS INDICATED ABOVE. FOR THIS PURPOSE ADDITIONAL STAFF SHOULD BE PROVIDED TO THE LADY HARDINGE HOSPITAL, THE A.I.I.M.S. AND THE MAULANA AZAD MEDICAL COLLEGE.

(46) THAT THE LABORATORY SERVICE OF THESE HOSPITALS SHOULD CONSIST OF A DIVISION OF HAEMATOLOGY INCLUDING BLOOD BANK, MICROBIOLOGY INCLUDING PARASITOLOGY AND IMMUNOLOGY AND CHEMICAL PATHOLOGY (BIOCHEMISTRY). EACH OF THESE DIVISIONS SHOULD BE UNDER ONE OR MORE WELL TRAINED OFFICERS.

(47) THAT THE SENIOR MOST OFFICER IN CHARGE OF LABORATORIES SHOULD BE THE HEAD OF THE DEPARTMENT WITH THE SPECIFIC FUNCTIONS OF COORDINATING THE ACTIVITIES OF THE VARIOUS DIVISIONS.

(48) THAT THE TECHNICAL STAFF SHOULD CONSIST OF ONE TECHNICAL TUTOR IN OVERALL SUPERVISION. EACH OF THE DIVISIONS SHOULD BE UNDER ONE TECHNICAL ASSISTANT WITH SENIOR AND JUNIOR LABORATORY TECHNICIANS DEPENDING UPON THE WORKLOAD.

(49) THAT THE TECHNIQUES USED BY THESE LABORATORIES SHOULD BE STANDARDISED AND A LABORATORY MANUAL BE PREPARED WHICH SHOULD BE FOLLOWED BY EACH OF THE HOSPITALS.

(50) THAT EACH OF THE HOSPITALS MUST ORGANISE A CENTRAL COLLECTION ROOM TO COLLECT ALL SPECIMENS AND DISBURSE THEM TO THE RESPECTIVE DIVISIONS.

(51) THAT THE EMERGENCY LABORATORY SHOULD BE SITUATED IN CLOSE PROXIMITY TO THE INTENSIVE CARE AND EMERGENCY SERVICE UNITS OF THE HOSPITAL. IT SHOULD PROVIDE AN EFFICIENT ROUND THE CLOCK SERVICE UNDER A TECHNICAL ASSISTANT OR SENIOR TECHNICIAN. THE WORK OF THE EMERGENCY LABORATORY SHOULD BE SUPERVISED IN ROTATION BY ONE OF THE OFFICERS OF THE MAIN LABORATORIES. THE EMERGENCY LABORATORY SHOULD UNDERTAKE TOTAL AND DIFFERENTIAL COUNTS OF BLOOD AND C.S.F. ESTIMATIONS OF HAEMOGLOBIN, BILIRUBIN, BLOOD UREA, BLOOD SUGAR AND BLOOD ELECTROLYTES.

(52) THAT THE OUT PATIENTS LABORATORY SHOULD BE LOCATED NEAR THE CENTRAL COLLECTION ROOM AND SHOULD UNDERTAKE THE FOLLOWING INVESTIGATIONS:

- a) HAEMATOLOGICAL: TOTAL AND DIFFERENTIAL COUNTS OF BLOOD AND C.S.F., HAEMOGLOB. SEDIMENTATION RATE, PROTHROMBIN TIME AND BLEEDING AND CLOTTING TIME, SUPERVISED BY THE HAEMATOLOGY SECTION.

b) BIOCHEMISTRY; ROUTINE AND MICROSCOPIC  
EXAMINATION OF URINE, SUPERVISED BY  
THE BIOCHEMISTRY DEPARTMENT.

c) MICROBIOLOGY: ROUTINE STOOL EXAMINATION UNDER  
THE SUPERVISION OF MICROBIOLOGY  
SECTION.

(53) THAT EACH OF THE DIVISIONAL LABORATORIES  
SHOULD WORK AS "IN-DOOR LABORATORIES" AND APART  
FROM UNDERTAKING MORE SOPHISTICATED AND COMPLICATED  
TECHNIQUES, SHOULD CONSTANTLY SUPERVISE AND ENSURE  
PROPER CONTROL OF THE QUALITY OF WORK IN THE  
OUT-PATIENTS AND EMERGENCY LABORATORIES.

(54) THAT EACH OF THE LABORATORIES SHOULD  
BE PROPERLY EQUIPPED WITH PHOTOELECTRIC  
COLORIMETER, FLAME PHOTO-METER, GREY WEDGE  
PHOTOMETERS AND OTHER EQUIPMENTS ESSENTIAL  
TO PERFORM DIFFERENT TESTS UNDER STANDARD  
CONDITIONS.

122. As regards the second category of hospitals, while the specialised services like Morbid Anatomy, Microbiology and Biochemistry are well organised by the respective Departments of the College, one of the greatest lacunae in all the attached hospitals is the lack of organisation of proper services for "routine laboratory" work. For the sake of achieving "patient care" of a high order, it is essential that the parent Departments must be made entirely responsible for the quality of the hospital services offered by that so called "clinical laboratories". This can be easily achieved with minor addition to the staff.

It is imperative that the Biochemistry Departments of the Colleges should take over the responsibilities of biochemical investigations of the attached hospitals. The quality control and the techniques employed by this laboratory should be under the constant supervision of trained Biochemists in different fields.

The Department of Microbiology including the Divisions of Immunology, Parasitology and Virology must take over the hospital load and exercise such control that will ensure proper quality of work.

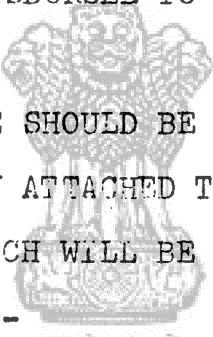
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The Committee recommends

(55) THAT THE PARENT DEPARTMENTS OF PATHOLOGY INCLUDING HAEMATOLOGY, MICROBIOLOGY INCLUDING PARASITOLOGY, VIROLOGY AND IMMUNOLOGY AND BIOCHEMISTRY SHOULD BE RESPONSIBLE FOR THE "CLINICAL PATHOLOGY" WORK OF THE ATTACHED HOSPITALS.

(56) THAT THERE SHOULD BE A WELL ORGANISED CENTRAL COLLECTION ROOM WHERE ALL SPECIMENS, BOTH OF INPATIENTS AND OUT-PATIENTS SERVICES, ARE RECEIVED AND DISBURSED TO THE PARENT DEPARTMENTS.

(57) THAT THERE SHOULD BE AN OUT-PATIENTS CLINICAL LABOPATORY ATTACHED TO THE CENTRAL COLLECTION ROOM WHICH WILL BE RESPONSIBLE FOR SUCH TECHNIQUES AS:-

- 
- a) TOTAL AND DIFFERENTIAL COUNTS,  
ESTIMATIONS OF HAEMOGLOBIN,  
SEDIMENTATION RATE, PROTHROMBIN  
TIME, CLOTTING AND BLEEDING TIME.
- b) ROUTINE EXAMINATION OF URINE.
- c) ROUTINE EXAMINATION OF STOOL.

THESE SHOULD BE UNDER THE TECHNICAL GUIDANCE OF THE PROSPECTIVE DEPARTMENTS.

(58) THAT AN OFFICER OF THE RANK OF ASSISTANT PROFESSOR OR ABOVE FROM THE PARENT DEPARTMENTS SHOULD BE POSTED IN ROTATION TO THE CENTRAL



COLLECTION ROOM IN OVERALL CHARGE FOR COORDINATION AND EFFICIENCY.

(59) THAT BOTH THE CENTRAL COLLECTION ROOM AND THE OUT-PATIENTS LABORATORY SHOULD HAVE FULL COMPLEMENT OF TECHNICAL STAFF SUCH AS TECHNICAL ASSISTANTS, SENIOR AND JUNIOR LABORATORY TECHNICIANS , WHO CAN CARRY ON THE WORK EFFECTIVELY UNDER SUPERVISION.

(60) THAT THE EMERGENCY LABORATORY SHOULD BE LOCATED IN CLOSE PROXIMITY TO THE INTENSIVE CARE AND THE EMERGENCY WARDS. THIS SHOULD BE PRIMARILY UNDER THE DEPARTMENT OF BIOCHEMISTRY WHO WILL BE RESPONSIBLE FOR QUALITY CONTROL OF THE WORK DONE AND WILL BE ASSISTED BY THE DEPARTMENTS OF PATHOLOGY, HAEMATOLOGY AND MICROBIOLOGY.

(61) THAT THERE SHOULD BE A ROUND THE CLOCK AUTOPSY SERVICE ORGANISED BY THE DEPARTMENT OF MORBID ANATOMY SO THAT THE AUTOPSIES CAN BE PERFORMED WITHIN A FEW MINUTES OF DEATH.

RADIOLOGICAL DEPARTMENT123. Radiodiagnosis:

Radiological Department in almost all hospitals has expanded during the years with the increasing volume of work. Its growth pattern has not been on rational lines. The quantum of work is over on the increase both from out-patients and in-patients. Accommodation for additional units is provided by make shift arrangements. This obstructs the normal flow of work and traffic in the department. Generally sandwiched between other hospital departments, the potential of allocation of further accommodation is limited. The department with a dull dreary outlook gives a cold reception to the patient already afraid of the outcome of his illness and apprehensive of what the X-ray examination would reveal.

Considering the growing demands on X-ray services, the Committee suggests that the radiological department should have an effective appointment system which should enable patients needing radiological service to report at the department at the appointed time. There should be comfortable waiting and dressing room accommodation. Proper arrangements should be made for patients sent from wards. In particular patients on trolleys and wheel chairs should not be made to wait in the department for hours.

Well trained radiographers will improve the quality of the X-ray pictures and thus improve the efficiency of this department which at present is unsatisfactory.

All hospitals handle emergencies. They need 24 hours emergency radiological service. Trained technicians should be employed- They should be available by turn after the department is closed. In hospitals where the calls are less frequent radiographer should be available on call. This is feasible when residence in or near the hospital is provided. The service provided at the Lady Hardinge and the Hindu Rao hospital should be strengthened by additional technical staff to give round the clock service.

Such hospitals which have emergency ward attached to Emergency and Accident Department, provision of X-ray plant should be made in the emergency department. It is desirable to have screening facilities in the busy medical out-patients of the hospital. Arrangements for radiological investigations should be available in operation theatres.

All hospitals should ensure that the X-ray photographers with reports are made available expeditiously to out-patients and wards within 24 hours.

Because of medicolegal work radiologists have to attend the courts. Reduction of manpower on this account should be kept in view in deciding the number of qualified radiologists in hospitals.

X-ray photographers are valuable documents. These need to be preserved and should be available for comparison when a patient reports after some years. There should be proper documentation before the photograph is sent to the OPD or the ward and it should be returned to the X-ray department on the discharge of the patient for proper filing.

The number of X-ray machines is not sufficient. Additional machines are required in all hospitals, in particular for specialised examination. In the Lady Hardinge and the Hindu Rao Hospital the deficiencies should be rectified immediately.

124. Radiotherapy: The radiotherapy department can best be centralised in a few hospitals to which cases can be referred from other hospitals. All teaching hospitals should have radiotherapy facilities with adequate number of beds. The radiotherapy department in the Safdarjang and the Irwin hospitals are well equipped and function satisfactorily. The ill-equipped radio-therapy department in the Lady Hardinge hospital should be reorganised to provide the

much needed service in the biggest women's hospital in Delhi. This is also referred to later.

The Committee recommends:

Radiology (Diagnostic)

(62) THAT THE EXISTING PHYSICAL FACILITIES OF THE RADIOLOGY DEPARTMENT, WHEREVER SHORT, SHOULD BE AUGMENTED BOTH FOR THE EFFICIENCY OF THE SERVICE AND THE COMFORT OF PATIENTS.

(63) THAT MORE TRAINED RADIOLOGISTS SHOULD BE APPOINTED SO THAT THEY CAN PERFORM THEIR DUTIES EXPEDITIOUSLY AND EFFICIENTLY.

(64) THAT THE NUMBER OF TRAINED RADIOGRAPHERS AND DARK ROOM ASSISTANTS SHOULD BE INCREASED DEPENDING ON THE WORKLOAD AND PARTICULARLY TO ENSURE A PROPER EMERGENCY SERVICE.

(65) THAT TO AVOID OVERCROWDING IN THE WARDS IT IS NECESSARY TO INTRODUCE A PROPER "APPOINTMENT SYSTEM" FOR INVESTIGATION FROM "OUT-PATIENT DEPARTMENTS". NO SUCH INVESTIGATION SHOULD BE DEFERRED FOR MORE THAN A WEEK.

(66) THAT ROUND THE CLOCK EMERGENCY RADIOLOGICAL COVER SHOULD BE PROVIDED. THIS SHOULD BE LOCATED NEAR THE EMERGENCY WARD OF THE HOSPITAL.

(67) THAT THE DEPARTMENT SHOULD BE PROVIDED WITH STENOGRAPHER AND OTHER ANCILIARY STAFF TO ENSURE PROPER DOCUMENTATION AND REPORTING.

(68) THAT PROPER STORAGE FACILITIES BE PROVIDED TO THE DEPARTMENT FOR SYSTEMATIC FILING OF X-RAY PICTURES.

(69) THAT THE X-RAY PICTURES SHOULD BE REGARDED AS DOCUMENTS ON CHARGE OF THE RADIOLOGY DEPARTMENT AND SHOULD BE RETURNED TO THE DEPARTMENT BY THE CLINICIANS FOR THE PURPOSE OF RECORDING AND FILING.

Radio Therapy Department

(70) THAT SUCH THERAPY UNITS SHOULD HAVE THE COBALT BOMB, RADIO ACTIVE ISOTOPES, RADIUM AND CONVENTIONAL RADIO THERAPY UNIT ETC. AS THE MINIMUM AVAILABLE FACILITIES.

(71) THAT A MINIMUM OF 20 BEDS SHOULD BE AVAILABLE TO THE THERAPY UNIT UNDER THE DIRECT SUPERVISION OF A COMPETENT RADIO THERAPIST.

(72) THAT REGULAR CANCER CLINICS SHOULD BE INTRODUCED IN WHICH THE RADIO THERAPISTS, THE CLINICIANS AND THE PATHOLOGISTS SHOULD DISCUSS THE APPROPRIATE LINE OF THERAPY FOR EACH CASE.

(73) THAT THERE SHOULD BE A PROPER "FOLLOW UP" CLINIC.

(74) THAT THE RADIO THERAPY UNIT SHOULD BE HOUSED SEPARATELY FROM THE RADIO DIAGNOSTIC UNITS AND SHOULD HAVE AN INDEPENDENT COMPLIMENT OF STAFF.

(75) THAT A RADIO BEAM PHYSICIST SHOULD BE APPOINTED IN ALL RADIO THERAPY UNITS.

(76) THAT SUCH THERAPY UNITS BE CONCENTRATED AROUND THE PRESENT NUCLEUS OF RADIO THERAPY UNITS AT THE MAULANA AZAD MEDICAL COLLEGE, ALL INDIA INSTITUTE OF MEDICAL SCIENCES/ SAFDARJANG HOSPITALS. THESE SHOULD BE EXTENDED AND INTEGRATED FOR MORE EFFECTIVE SERVICE.

(77) THAT THE RADIO THERAPY UNIT IN THE LADY HARDINGE MEDICAL COLLEGE SHOULD BE DEVELOPED AND SHOULD CONCENTRATE ON RADIO THERAPY IN GYNAECOLOGICAL CASES FOR PURPOSES OF TREATMENT AND FOLLOW-UP.

### BLOOD BANK

125. The Blood Banks in all hospitals depend mainly on paid donors. This is not a happy situation. Concerted efforts to build up a voluntary blood donation corps should be undertaken. Blood Banks in all hospitals should provide a 24 hours service.

For proper cleaning of blood transfusion apparatus, it is essential that automatic bottle cleaning machines are installed in all Blood Banks.

The preparation of infusion fluids should not be the responsibility of the Blood Bank. This is the function of the pharmacy and dispensing service and should be transferred to them as part of their legitimate activity.

The Lady Hardinge hospital which has to deal with Obstetric emergencies should have a round the clock blood transfusion service. The Committee recommends that immediate attention should be paid to organise a Blood Bank, properly equipped and staffed. Considering the requirements of fresh blood in the hospitals in Delhi, it is considered that a Central Blood Bank service will work more effectively. All hospitals should, however, have a blood dispensing service where limited stocks are held and bleeding of relatives of patients undertaken.

The Committee recommends:

(78) THAT A CENTRAL BLOOD BANK SHOULD BE STARTED IN A SUITABLE LOCATION IN DELHI TO FEED THE SUBSIDIARY BLOOD BANKS IN HOSPITALS. TILL SUCH TIME THIS IS



POSSIBLE, THE BLOOD BANK AT THE SAEDARJANG HOSPITAL SHOULD BE CONVERTED INTO A CENTRAL BLOOD BANK.

(79) THAT THE CENTRAL BLOOD BANK AND OTHER SUBSIDIARY BANKS SHOULD DEPEND ON "VOLUNTARY" RATHER THAN ON THE "PAID" DONORS. THE CENTRAL BLOOD BANK SHOULD DEVISE METHODS FOR ADEQUATE PROPAGANDA AND EDUCATION TO TAP THE HUGE RESOURCES OF DELHI FOR THIS PURPOSE.

(80) THAT THE CENTRAL BLOOD BANK SHOULD ORGANISE MOBILE COLLECTION TEAMS, CENTRAL REGISTRATION, DOCUMENTATION OF RARE BLOOD GROUPS, DISSEMINATION OF KNOWLEDGE AND COLLECTION OF BLOOD FROM VARIOUS INSTITUTIONS AND OFFICES IN AND AROUND DELHI.

(81) THAT THE HOSPITAL BLOOD BANK SHOULD CONTINUE TO FUNCTION AS A DISPENSING UNIT AND ALSO TO COLLECT BLOOD FROM RELATIVES AND FRIENDS OF PATIENTS IN THE HOSPITAL, SUCH BLOOD BANKS SHOULD OFFER A 24 HOURS SERVICE.

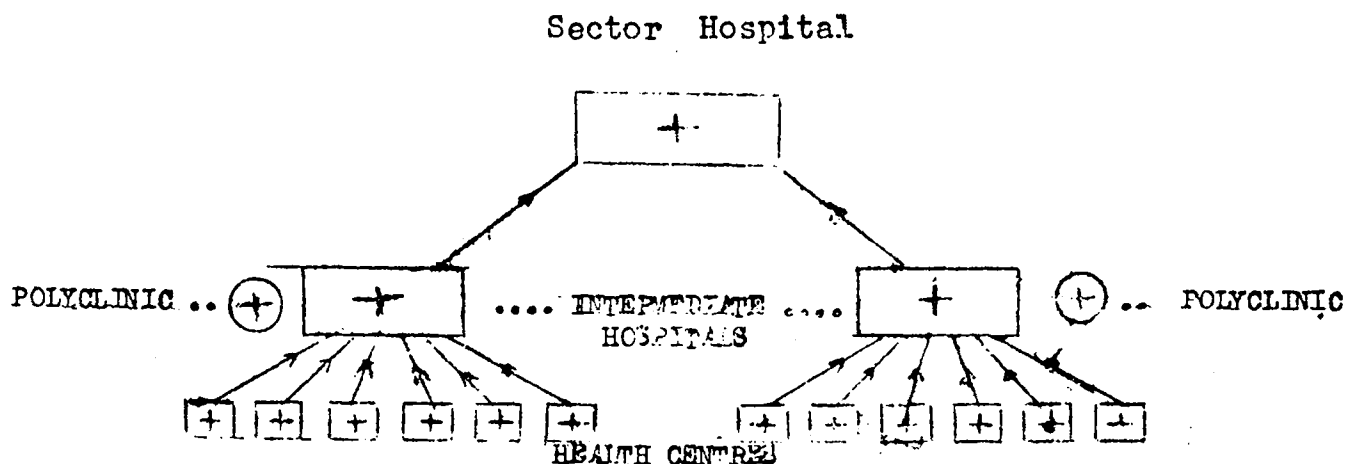
(82) THAT THE HOSPITAL BLOOD BANK SHOULD DEVOTE MORE TIME FOR DIFFERENT IMMUNOLOGICAL AND OTHER INVESTIGATIONS THAT EMERGE OUT OF TRANSFUSION.

(83) THAT THE BLOOD BANK IN HOSPITAL SHOULD NOT BE BURDENED WITH PREPARATION OF OTHER INFUSION FLUIDS.

Medical Service:

126. Out-patients: Overcrowding in OPD is one of the major causes of complaints. This is due mainly to inadequacy in the number of peripheral health centres and poly-clinics. In the absence of any organised system of medical care at the periphery, a patient is at liberty to visit any hospital. Besides, all types of patients with minor ailments as well as those requiring only investigation go to the sector hospitals as there are no facilities in the periphery to screen such cases and channelise only those that require attention at the Sector Hospitals. The Sector hospital outpatient departments, instead of functioning as referral and consultant out-patients, are today dealing with a large number of minor cases who could have been disposed of by better organised peripheral health centres, poly clinics or intermediate hospitals. The Committee is of the considered view that it is necessary to strengthen the front line by better organised and larger number of health centres and that between the health centres and the sector hospitals, a number of polyclinics with Intermediate Hospitals should be established. This will stream line the flow of patients from the front to the rear and reduce the

Load on the Sector Hospitals as indicated below:



The staff for registration at OPD is not adequate. In the Committee's view the current practice of detailing pharmacists for registration work is a waste of technical man-power. This should be entrusted to clerks and the pharmacists withdrawn forthwith for their legitimate dispensing duties.

In the Willington Hospital the Public Relations Services should be strengthened.

The present situation of the OPD in Safdarjang Hospital dispersed in different parts of hospital has to be rectified. The hospital has a proposal to construct a new OPD block. The Committee favours the integration of the Safdarjang and the All India Institute of Medical Sciences. The OPD block of the All India Institute of Medical Sciences should be used in the morning as general OPD for both hospitals.

Specialised clinics should be conducted in the afternoon. The construction project for a separate OPD block for Safdarjang Hospital may await the decision on the question of integration.

Additional accommodation is recommended to meet the requirements of the out-patients department of the Kalavati Saran Children's Hospital.

Additional consulting room accommodation is needed for the medical and surgical OPD of the Irwin Hospital, to cater to the needs of this hospital and G.B. Pant Hospital. As long as the Irwin hospital OPD continues to function as a G.P. centre, no amount of additional accommodation will solve the problem of overcrowding. The Committee recommends that peripheral OPD service should be organised and improved at the health centres in Jama Masjid, Lal Kuan, Chandni Chowk and Ajmeri Gate areas.

The G.B. Pant Hospital being a specialist hospital should not hold general OPD but hold clinics at the OPD of the Irwin Hospital in the afternoon. No patient should be attended to without a reference. The present accommodation allocated for specialists' clinics of this hospital in the OPD of Irwin Hospital is, however, inadequate. Adequate accommodation

should be made available for holding clinics. Investigation facilities of ECG, X-ray, clinical and bio-chemical laboratory should be available in the afternoon at the time of clinics.

The Hindu Rao Hospital being the only hospital in the north sector of Delhi with a daily attendance of about 1200, the Committee recommends that a new OPD block be constructed to provide for consultations in general medicine, surgery, Eye and ENT, children's diseases, Obstetrics and Gynaecology and dental. It should have 15-20 consultants' suites, besides central waiting and registration, sub-waitings, dispensing facilities, injection rooms, dressing rooms, separately for men and women, as also separate for general surgery and Eye and ENT. A psychiatrist and a dermatologist should also be posted to the hospital.

The Committee recommends:

(84) THAT TECHNICAL PERSONS LIKE PHARMACISTS SHOULD BE RELIEVED OF REGISTRATION WORK IN THE OPD AND OTHER NON-TECHNICAL DUTIES OF THE HOSPITALS. THIS WORK SHOULD BE DONE BY THE MINISTERIAL STAFF.

(85) THAT AN ENQUIRY COUNTER WITH ADEQUATE STAFF IS ESSENTIAL IN THE OPD OF ALL HOSPITALS TO GUIDE PATIENTS TO THE DIFFERENT DEPARTMENTS.

(86) THAT ADEQUATE X-RAY AND LABORATORY FACILITIES SHOULD BE AVAILABLE IN THE OPD TO CONSERVE THE OCCUPATION OF COSTLY BEDS BY PATIENTS NEEDING ONLY INVESTIGATION AND OUTDOOR TREATMENT.

(87) THAT AT THE HOSPITAL OPD ARRANGEMENTS FOR PREVENTIVE HEALTH MEASURES AND HEALTH EDUCATION SHOULD BE MADE.

(88) THAT A WELL ORGANISED OPD BE PROVIDED IN THE SAFDARJANG HOSPITAL.

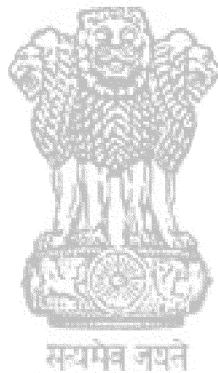
(89) THAT THE OUT-PATIENT DEPARTMENT IN THE KALAVATI SARAN CHILDREN'S HOSPITAL SHOULD BE EXPANDED TO MEET THE GROWING DEMAND.

(90) THAT ADDITIONAL CONSULTING ROOMS ARE REQUIRED IN THE OPD OF THE IRWIN HOSPITAL, PARTICULARLY IN THE MEDICAL, SURGICAL AND SPECIALISTS CLINICS TO MEET THE REQUIREMENTS OF THIS HOSPITAL AND G.B. PANT HOSPITAL.

(91) THAT THE CONSTRUCTION OF A NEW OPD BLOCK IN THE HINDU RAO HOSPITAL BE EXPEDITED ON PRIORITY.

(92) THAT THE POSTS OF PSYCHIATRIST AND DERMATOLOGIST IN THE HINDU RAO HOSPITAL SHOULD BE FILLED.

(93) THAT WAITING SPACE IN THE OPD SHOULD BE ADEQUATE, WELL-FURNISHED AND VENTILATED AND PROVIDE SUFFICIENT NUMBER OF WATER-CLOSETS. A CONTINUOUS SUPPLY OF COLD DRINKING WATER SHOULD BE AVAILABLE.



Inpatients:

127. The main reasons ~~for over-crowding~~ in wards and pressure on inpatients beds are (a) lack of screening of admission at OPD; (b) delay in disposal of patients due to lack of operation theatre facilities; (c) occupation of beds by patients needing investigations; and (d) accumulation of chronic and convalescent cases. Many patients who really need beds are denied these because of non-availability. The Committee feels that organising peripheral health centres with adequate diagnostic facilities and domiciliary specialist cover will not only improve the quality of out-patient service but will also make it possible for doctors to screen admissions adequately.

To improve the turn-over, the Committee recommends that all patients in the wards should be screened by the head of the unit on the day of admission so that un-necessary cases can be discharged with minimum delay. Further, strengthening of the diagnostic facilities and provision of adequate numbers of operation theatres will reduce delay in the disposal of patients awaiting investigation/operation.

The Committee considers that the bigger general hospitals should develop a system of progressive patient care. This will relieve pressure on wards where acute patients are



treated. Each hospital should organise an intensive care unit of 4-6 beds. The detailed requirements of such a unit are discussed in the subsequent section. A separate room for the patients' attendants with toilet and changing facilities should be provided in this unit.

To relieve the pressure on costly beds occupied by chronic cases e.g. para-plegics and other invalids and patients requiring rehabilitation or prothesis should be kept in separate wards in the hospital where chronic patients are accommodated in cheap design buildings with suitable nursing care.

The wards in general hospitals should be ideally small ones, accommodating 4-5 patients in each sick bay. Each ward unit of about 50 beds should be provided with a treatment room, a seminar room for students and a clinical side room with a laboratory technician. The ancillary facilities like day and dining rooms for ambulant patients, isolation rooms; locker facilities for patients, attendants and hospital staff, etc. should be adequately provided in each unit.

Because of inadequately developed laboratory and radiological services the quality of the patient care is apparently below par. The Committee therefore, does not recommend any further increase in the general beds to any of the three

hospitals - Willingdon, Safdarjang and Irwin.

What they recommend most now is strengthening of the diagnostic services and operation theatres and allied services. They should function as referral hospitals.

All hospitals should develop progressive medical care.

The inpatient care in the Lady Hardinge Hospital suffers because of inadequate diagnostic facilities - X-ray and laboratory - quantitatively and qualitatively, with no facility during night, absence of sterile supply and inadequate nursing care. The scale of equipment and personnel, both medical and non-medical, is much below that of other hospitals. Standard of cleanliness is also low. Further the hospital does not have modern equipment. Patient care will not improve unless the deficiencies in all these areas are made up. This teaching hospital should organise an intensive care unit and an emergency ward on the prescribed lines. Cleanliness in the wards in general and W.C. and bath rooms in particular should be improved.

In the Hindu Rao Hospital the existing scale of staff, nature and scale of equipment in the wards, and the quantum and extent of

supporting services are too inadequate to meet the requirements of a general hospital. At best the inpatient facilities can be equated to that of a Taluq hospital. This being the only general hospital in the north sector of Delhi, the Committee recommends that it needs strengthening in staff, medical and para-medical equipment and accommodation to play its due role. Medical staff of one specialist and two assistant surgeons in one unit is far from adequate, particularly in general medicine and surgery, to attend to 50 beds and an out-patient load of about 500 to 600 a day. As long as the quality of medical care is not improved in this hospital the pressure on the Irwin Hospital will continue. सत्यमेव जयते

128. Progressive Medical Care: The three components of progressive patient care are:-

- Intensive care or therapy;
- Intermediate care; and
- Self care; or convalescent.

Intensive therapy or care means continuous attention and treatment given in specially equipped Units by specially trained and permanent teams of nurses and doctors. The three essentials of intensive therapy are:-

- (a) A therapeutic team composed of:
  - (i) a permanent nursing complement specifically trained and giving continuous service, and
  - (ii) readily available medical manpower.
- (b) An "area", "Unit" or "Facility", with equipment readily available and adequately maintained.
- (c) Standardised technique of investigation and treatment.

The admission to the intensive care unit should normally come from the following departments:-

- (a) Intermediate Care ward;
- (b) From the parent hospital;
- (c) Operation Theatre or recovery room;
- (d) Casualty room and accident unit.

The functions of the intensive therapy unit are as under:-

Paralytic respiratory failure, burn (separate unit for children and adults) thoracic surgery, neo-natal surgery, neuro-surgery, dialyses unit, internal medicine and surgery including coronary care and paediatric medicine.

The staff required are:-

Physician, surgeon and anaesthetist, casualty medical officer, accident surgeon, and their assistants, The other doctors who will actively participate in treatment are orthopaedic surgeon and obstetrician; Doctors who can be called for consultation like psychiatrists and neurologists; Doctors in ancillary services like Radiologists and Bacteriologists.

Most of the patients admitted in the intensive therapy unit require intensive nursing care or "heavy nursing". The nurse is a therapist and the most important administrator of drugs, infusion, gases and food. She carries out the specialised observations and treatment given in the unit; e.g. electronic monitoring, intermittent positive pressure, ventilation of haemodialysis.

Structure of medical team

Doctors with regular duties in the Unit:

Consultants, e.g. thoracic surgeon, anaesthetist; Junior Staff, e.g. SHO in medicine

Doctors who refer ~~patients~~ and who actively participate in the treatment, e.g. orthopaedic surgeon, accident surgeon, obstetrician.

Doctors called in for consultation, e.g. psychiatrist, neurologist.

Co-ordinator, referee or chairman of therapy.

Doctors in the ancillary hospital services, e.g. radiologist, bacteriologist.

#### Methods of Intensive Therapy

Intensive therapy requires standardised methods of investigation and treatment of patients admitted to the unit. In addition to the accurate and continuous clinical observation each plan of therapy usually needs to be controlled by repeated scientific measurements.

#### Basis of intensive therapy

##### (1) Metabolic

Food, drugs, water and electrolytes via GIT and intravenous infusion

Blood transfusion

Exchanges viz GIT or peritoneum, e.g. suction, resins or dialysis

Haemodialysis

By-pass oxygenation

## (ii) Respiratory

Inspired gasses modified in composition  
or pressure IPV

## (iii) Surgical and Mechanical Organ transplant,

Tracheostomy Bronchial lavage

Scribner Shunt, Cough machines, IPPV

## (iv) Electrophysiological cardioversion,

Pacing, Defibrillation

## Result of Intensive Therapy;

For cases of myocardial infarction, thoracic surgery, acute renal failure, respiratory failure due to asthma and chronic lung diseases are due to chest injuries or because of poisoning.

The first aim of therapy is to reduce mortality and morbidity. The intensive therapy benefits the patient who can be treated more effectively by the therapeutic team of an I.T.U. and with less disturbance to other patients.

The closer contact of doctor and patient and his relatives means that the patient is less likely to be dehumanized by the doctor than in the other parts of the hospital. The distress to the patient caused by the disease and its treatment and the anxiety to his relatives largely depend on the duration of the therapy. Success spells survival and the distresses are soon forgotten. Failure of resuscitation means a short battle and failure means death.

The Committee recommends:-

- (94) THAT A SYSTEM OF PROGRESSIVE PATIENT-CARE SHOULD BE ORGANISED IN EACH HOSPITAL.
- (95) THAT EACH HOSPITAL SHOULD ORGANISE AN INTENSIVE CARE UNIT OF 4-6 BEDS AND A POST-OPERATION WARD OF 10-20 BEDS, PROPERLY EQUIPPED FOR RESUSCITATION, WITH ROUND THE CLOCK NURSING, LABORATORY SERVICE AND ATTENTION BY SPECIALISTS.
- (96) THAT ACCOMMODATION IN GENERAL WARDS SHOULD PREFERABLY BE IN SMALLER UNITS i.e., SICK-BAYS WITH 4 TO 6 PATIENTS.
- (97) THAT EACH UNIT OF ABOUT 50 BEDS SHOULD BE PROVIDED WITH A TREATMENT ROOM, A CLINICAL SIDE ROOM AND A SEMINAR ROOM FOR TEACHING.

As for the individual hospitals the Committee recommends:-

- (98) THAT NO ADDITIONAL BEDS BE ADDED TO THE WILLINGDON, SAFDARJANG AND IRWIN HOSPITALS. THE INPATIENT SERVICES AT PRESENT AVAILABLE SHOULD BE CONSOLIDATED.



- (99) THAT INTENSIVE-CARE UNITS SHOULD BE ORGANIZED IN THE WILLINGDON, A.I.I.M.S., THE LADY HARDINGE, THE IRWIN AND THE SAFDARJANG HOSPITALS.
- (100) THAT IN THE HINDU RAO HOSPITAL SHORTAGE OF STAFF, DEFICIENCY IN EQUIPMENT AND THE SUPPORTING SERVICES SHOULD BE IMMEDIATELY REMEDIED.
- (101) THAT NURSING HOME FACILITIES IN WILLINGDON HOSPITAL SHOULD BE AVAILABLE FOR ALL THE SPECIALISTS. ADMISSION TO THE NURSING HOME SHOULD BE DONE ACCORDING TO WAITING LIST AS THE VACANCY OCCURS.

Paediatrics:

129. About 40% of the attendance at the health centres is by children. Adequate facilities are required to attend to the special needs of this group.

The Paediatrics service cannot be considered as satisfactory in any of the general hospitals. It would be preferable to locate the children's out-patients and inpatients in the same unit. A separate casualty service for children is desirable. As far as possible not more than 4 children should be kept in a sick bay. For every 40 beds an intensive therapy unit not exceeding 4 beds should be provided.

Mothers who have to stay with their children in Children's wards should be afforded facilities for the same, including toilet and changing room.

Over-crowding and unhygienic conditions favour cross-infection in wards. The Micro-technique laboratory facilities are inadequate.

The microtechnique laboratory in the Irwin hospital children's unit needs to be attended to immediately. Additional staff is required. Arrangements for paediatric surgery should be made.

The micro-technique laboratory attached to the paediatrics unit of the Safdarjang Hospital should be adequately staffed and accommodated and the costly equipment for estimation of electrolytes put in working order.

In addition to the existing facilities in the Irwin and Kalawati Saran Hospitals a special unit is needed in each of these hospitals for the care of premature infants, whether born in the hospital or outside, who need highly skilled and specialised care if they are to survive.

The Committee recommends:-

(102) THAT ALL PAEDIATRIC UNITS SHOULD HAVE A WELL EQUIPPED MICRO-TECHNIQUE LABORATORY PROVIDING ROUND THE CLOCK SERVICE WITH A QUALIFIED TRAINED TECHNICIAN UNDER SUPERVISION.

(103) THAT FOUR BEDS FOR EVERY 40 BEDS SHOULD BE AVAILABLE FOR THE TREATMENT OF ACUTELY ILL CHILDREN.

(104) THAT ARRANGEMENTS BE MADE FOR MOTHERS TO STAY IN THE HOSPITAL (CHILDREN'S WARDS) WITH SUFFICIENT FACILITIES FOR TOILET AND CHANGING ROOMS.

(105) THAT PREMATURE BABIES SHOULD BE TREATED IN PAEDIATRICS UNIT, EQUIPPED FOR IT.

(106) THAT PAEDIATRICS SURGICAL DEPARTMENT SHOULD BE DEVELOPED WITH PROPER EQUIPMENT AND STAFF IN KALAVATI SARAN CHILDREN'S HOSPITAL, ALL INDIA INSTITUTE OF MEDICAL SCIENCES, SAFDARJANG COMPLEX AND MAULANA AZAD COMPLEX.

Nursing Services:

130. It has to be accepted in the light of the existing overall shortage of nursing manpower in the country that these hospitals cannot depend entirely on other training institutions for trained nurses. They have to train their own. All the clinical material required for this is available in plenty. What is lacking is accommodation for nurses' training school and residential accommodation for trainee nurses. It will be in the interest of these institutions in particular and of the country as a whole to expand the facilities for training of nurses in these hospitals immediately by providing adequate accommodation.

The nursing situation is unsatisfactory; because:-

- (a) in view of the shortage of trained nurses, student nurses are utilised

for unsupervised patient care, to the detriment of their education as well as patient care.

- (b) overcrowding of wards upsets the nurse bed ratio thereby diluting attention to patients.
- (c) interference by the unions makes it difficult for even those who are prepared to perform their duties.
- (d) too much time is taken up in writing and stock taking and other non-technical work.

The College of Nursing in Delhi is functioning in isolation. In the training of graduate nurses, much due attention should be paid to patient-care and this is possible only in a hospital. It is therefore necessary that the College of Nursing should be an integral part of either the All India Institute of Medical Sciences or the Willingdon Hospital complex.

Married nurses are not fully utilised because of absence of residential accommodation in or near the hospital. The Committee recommends that married nurses should be engaged for part-time duties and residential accommodation should

be constructed for them near the hospital, wherever possible.

In working out the requirements of nursing personnel due allowance should be made for the number of nurses posted in out-patient and special departments, nurses on leave and additional needs of certain units like maternity, paediatric and intensive therapy, over and above the stipulated nurse patient ratio of 1:3 for teaching hospitals and 1:5 non-teaching hospitals.

The practice in some hospitals of having on night duty a single nurse for the whole floor, and that too a student nurse, should be stopped forthwith.

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The Committee recommends:

(107) THAT NURSES' RESIDENTIAL ACCOMMODATION SHOULD FIRST BE PROVIDED ON PRIORITY BEFORE ADDITIONAL BED STRENGTH IS SANCTIONED IN ANY HOSPITAL.

(108) THAT ALL HOSPITALS SHOULD EXPND FACILITIES FOR TRAINING OF NURSES. LACK OF ACCOMMODATION FOR TRAINING SCHOOL AND TRAINEES SHOULD BE REMEDIED IMMEDIATELY.

(109) THAT THE ALL INDIA INSTITUTE OF MEDICAL SCIENCES SHOULD START A NURSING TRAINING SCHOOL/ COLLEGE.

(110) THAT THE DELHI COLLEGE OF NURSING SHOULD FORM AN INTEGRAL PART OF THE ALL INDIA INSTITUTE OF MEDICAL SCIENCES OR ALTERNATIVELY BE BUILT IN CONJUNCTION WITH THE WILLINGDON HOSPITAL COMPLEX.

(111) THAT MARRIED NURSES SHOULD BE ENGAGED FOR PART-TIME DUTIES AND RESIDENTIAL ACCOMMODATION PROVIDED NEAR THE HOSPITAL WHEREVER POSSIBLE.

(112) THAT STUDENT NURSES BE NOT SOLELY RESPONSIBLE FOR PATIENT CARE ESPECIALLY ON THE NIGHT SHIFT.

(113) THAT THERE SHOULD BE SUFFICIENT AUXILIARY PERSONNEL DESIGNATED AS PRACTICAL NURSES OR WARD ORDERLIES WITH PROPER TRAINING TO PERFORM AS MUCH UNSKILLED WORK AS POSSIBLE.

(114) THAT THE NURSING SUPERINTENDENT SHOULD HAVE MORE EFFECTIVE CONTROL OVER THE WARD/ OPERATION THEATRES ETC. TO ENSURE MAINTENANCE OF SANITATION, CLEANLINESS AND WARD DISCIPLINE.

#### Dental Health:

131. All the hospitals have a dental unit. The principal activity centres round oral surgery. Arrangement for prosthodontic service exists only in the Irwin and the Safdarjang Hospitals. Even for oral surgery the facilities are limited. Oral Hygienists are not employed. The number of dentists is inadequate. In the

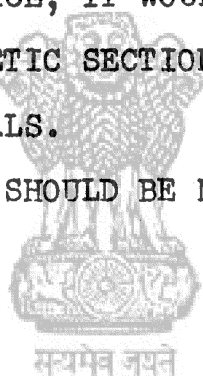
Safdarjang and the Irwin Hospitals where dentures are provided there is a long time lag ranging from 6 months to 1½ years. This can hardly be considered a satisfactory situation.

The Committee recommends:

(115) THAT THE DENTAL SERVICE IN ALL THE HOSPITALS SHOULD BE ORGANISED TO MEET THE BASIC NEEDS OF THE POPULATION IT SERVES.

(116) THAT IN ADDITION TO THE STRENGTHENING OF ORAL SURGERY SERVICE, IT WOULD BE DESIRABLE TO SET UP THE PROSTHETIC SECTION IN THE DENTAL DEPARTMENT OF HOSPITALS.

(117) THAT DENTURE SHOULD BE MADE AVAILABLE AT SUBSIDIZED RATES.





### Surgical services:

132. Although the various services which comprise surgical service exist in all hospitals in Delhi in varying degrees of development, considerable augmentation and improvement are required to raise the quality of this service to the requisite standard. The deficiencies noticed are in respect of physical facilities, qualified and experienced specialists of appropriate standing, well trained technicians, modern equipment and efficient supporting services. The tendency on the part of all hospitals to develop highly specialised disciplines as prestige symbols when the available facilities are hardly adequate to provide routine surgical service should be curbed. The above deficiencies have also had their adverse effect on the teaching responsibilities of these hospitals.

### Rehabilitation:

132-A. The rehabilitation services are not uniformly well developed in all the institutions. Trained staff, particularly physiotherapists, equipment and physical

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facilities are inadequate. There are no facilities for manufacture of surgical appliances required for treatment and rehabilitation.

The Committee recommends:

- (117-A) THAT WELL EQUIPPED REHABILITATION CENTRES WITH TRAINED PHYSIOTHERAPISTS SHOULD BE ESTABLISHED IN ALL THE SECTOR HOSPITALS WHERE SUCH CENTRES DO NOT EXIST AND AUGMENTED WHERE THEY ARE SUB-STANDARD.
- (117-B) THAT A PROSTHETIC WORKSHOP BE ESTABLISHED TO MEET THE REQUIREMENTS OF SURGICAL APPLIANCES OF ALL HOSPITALS IN DELHI.

133. The anaesthesia service in these hospitals must be completely reorganised to provide round the clock specialist service for emergencies. The Chief Anaesthetist should be responsible for the efficiency of the operation theatre service, post-operative care and supporting services like central sterile supply, central supply of gases etc. He should also be actively associated with the prevention of hospital infection.

P.T.O.

Obstetrics & Gynaecology:

134. In the prevailing conditions of over-crowding, lack of physical facilities in the form of separate operation theatres and labour rooms for clean and septic cases and inadequacies of supportive services like diagnostic facilities, blood bank and Central Sterile supply, cross infection is inevitable. The problem is real and urgent and cannot be solved by make-shift arrangements or improvisations. Immediate action should be taken in the interests of the two highly vulnerable groups - the woman in labour and the new-born - to make up these essential requirements of the Obst. & Gyn. services in all Hospitals.

The department of Obstetrics & Gynaecology in the Lady Hardinge Hospital needs the support of a round the clock Blood Bank. The theatres, labour rooms, and central sterilisation service should be properly equipped and staffed. Clean sterile linen should be provided in adequate quantity.

Separate Gynaecology theatre should be earmarked in the Willingdon and other hospitals where at present Obstetrical and Gynaecological work is undertaken along with other disciplines.

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The Obstetrics and Gynaecology services in the Hindu Rao Hospital require to be completely reorganized and augmented.

135. As far the Obstetric service, the Committee is of the firm view that Delhi should have a unified maternity service for the metropolitan area, with active collaboration of Delhi Municipal Corporation, N.D.M.C. and other organisations undertaking this service. The ideal would be that 90% of the deliveries in the city should be done in hospitals. In a population of about 3-4 million provision of the number of beds required for about over a lakh of births annually would not be practicable. Domiciliary care based on main hospitals is the best alternative. The hospitals is the best alternative. The hospitals should take only cases requiring special attention and those who require sterilisation. They are:

All primigravida	-	15%
all women pregnant for the 3rd time	-	30%
those with complaints	-	5%
abortion	-	10%

Even for 60% of deliveries in hospital with an average hospital stay of 7 days about 1500 maternity beds are required. But Delhi has about 1150 obstetric and gynaecology beds in the Government, Municipal and private hospitals.

and of those about 25% are earmarked for Gynaecology. In fact only about 850 beds are available for maternity cases. The additional beds required should be found by establishing Municipal Maternity and Child Welfare Centres each with 20-30 beds attached to it. Screening of cases for deliveries will be done during the ante-natal period and only cases requiring specialist care referred to the nearest hospital.

The city should be divided in 4 zones - each zone having about 20-30 maternity and child welfare centres with referral attachment to a specialist hospital within the zone. The final year students of the medical college after having conducted deliveries should look after the maternity centres at night. The Junior Specialists from the hospital should visit these centres by rotation and screen cases for admission, and book them for delivery in the hospital.

Normal cases attending the ante-natal clinic of the specialist hospital, who are not expected to require specialist attention, will be diverted to the maternity centre nearest to their residences and booked for delivery in non-specialist hospitals. An inter-charges of Medical Officers working in the Corporation

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centres and hospitals will also help to improve the standard of obstetric service.

In case a sudden emergency occurs during delivery in the non-specialist hospital, a specialist from the referral hospital should be immediately summoned. A central ambulance service will be of great help to direct the ambulance to the specialist hospital for rushing the specialist and the emergency equipment to the required centre.

There should be a flying square service based on the specialist hospital, to rush to the home in a difficult case with a surgeon in charge of the team, emergency equipment, blood transfusion and other facilities.

These ambulances should be available to carry women for their delivery from their houses to the nearest hospital where the patient has been booked during the ante-natal care.

All women with three or more children can be sterilised after delivery under this scheme as they would all have been hospitalised in the specialist hospital. The maternity centres should also have family planning clinic attached so that the patients could be convinced of the necessity for planning parenthood.

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To sum up, the facilities required are:

Specialist hospitals in each zone.

Increase of beds in the Corporation maternity centres.

These maternity centres must be attached to the zonal specialist hospital.

Central ambulance service to cater to the four zones.

Cooperation of all the medical, nursing, para-medical and the final year students of the medical college.

The final year students, after having done the 20 deliveries in the specialist hospitals, should look after the maternity centres in the night. These students can be allotted to the centres to look after the deliveries during their three months posting on the obstetric side.

The Committee recommends:-

- 2 (118) THAT OBSTETRICS AND GYNAECOLOGY SERVICES AS A COMMUNITY HEALTH PROGRAMME SHOULD BE UNIFIED BY A CLOSER COLLABORATION OF DIFFERENT AGENCIES AND THE HOSPITALS UNDERTAKING THE SERVICES IN THE UNION TERRITORY OF DELHI.

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- (119) THAT EMPHASIS SHOULD BE ON DOMICILIARY CARE BASED ON THE ZONAL AND/OR AREA HOSPITAL.
- (120) THAT FAMILY WELFARE PLANNING AND SOCIAL OBSTETRICS SHOULD FORM AN INTEGRAL PART OF MATERNAL AND CHILD HEALTH SERVICES.

Operation Theatres:

136. The current practice is to group operating rooms together to form a single unit. These can be located in the lower floor preferably in one floor in the same wing with the central sterilization service placed in the basement connected with service lifts. Grouping of theatres facilitates maintenance of a high standard of asepsis by theatre superintendent and is more economical from the point of view of air-conditioning. Furthermore, the standards established for air hygiene in the operating room demand a complicated and expensive ventilating system. It will be almost impossible to provide this ventilating system at a number of points in the hospital. The window air-conditioners do not at all meet the requirement. The whole theatre block should preferably be centrally air-conditioned with positive pressure and 100% air replacement and provided with filters which will filter out



any particle more than five microns.

A modern operating room must be closed for use from time to time for maintenance. This also cannot be done in the present system of sharing of operation theatres by different specialities.

The number of operating rooms depends on the number of operations per day and the number of specialities. The usual practice followed is to have one operation theatre for 50 general surgical beds based on the assumption that the average stay of an operated case is for 10 days and that five operations can be performed in a day. Thus for a hospital with 200 surgical beds the number of operation theatres required for general surgery is four. This number refers to the main operating department and excludes operating rooms attached to the Casualty and Out-patient Departments which are extra. In addition each hospital should have a separate theatre for Gynaecology work, an independent ophthalmic theatre, and clean and septic maternity theatres. Orthopaedic surgery, neuro-surgery, cardiac surgery and paediatric surgery require specialised equipment. Separate theatres are considered necessary for such disciplines to accommodate bulky equipment and to ensure the requisite degree of asepsis.

Each operation suite includes an operating room, a lay-up room, nurses and instrument wash-up room, anaesthesia room, surgeons' wash-up room etc. These are all inter connected and positive pressure is maintained to ensure that air does not flow in from the corridor. Along with the corridor immediately leading to them, the operation suites form the clean zone.

Apart from the operating suite itself, other rooms like changing rooms, lavatories, showers, store rooms, instrument rooms, staff rest rooms, office for theatre superintendent are given to reduce the risk of infection being brought into operating suite itself. People entering the clean zone must pass through the changing room. Similarly, the patients, before being brought into theatre, pass through an interchange room before reaching the clean zone.

Operating rooms should be provided with anaesthesia gases and suction piped from the central supply system. These rooms also require a variety of electric points to work various items of equipment.

The use of central sterile supply department reduces the problem of over heating from sterilisers within the operating suite. The only sterilisers now required are small and high speed

automatic autoclaves designed to sterilise the surgeons' instruments only.

It is now a general practice to provide as close as possible to the operating room but outside the clean zone a separate recovery room for the reception of patients immediately following surgery. The usual provision is about three beds per operating room. Continuous supervision is essential. Special nursing staff under an experienced sister is assigned to this ward.

It is necessary that weekly check of the theatre should be carried out to ensure that all wires, ducts etc. are maintained in working condition. Germicidal ultraviolet lamps should be provided in corridor leading to operating theatre. All necessary precautions against fire, explosion etc. should be taken.

Judging from the requirements of a modern operation theatre in terms of the number, lay out, clean and dirty zones, equipment and piped medical gases, ventilation, central supply service, built in provisions to enforce asepsis etc, the Committee is convinced that it is well nigh impossible to ensure a fair degree of asepsis to carry out surgical work satisfactorily in any of the Delhi hospitals.

The Willingdon Hospital has only three equipped operating rooms. The two theatres viz., the emergency theatre and the septic theatre on ground floor in the main hospital should be immediately equipped and put into commission. In addition, three more theatres are required to separate the operative work of Eye and ENT from Gynaecology and to have a spare theatre for higher speciality.

In the Safdarjang Hospital with the commissioning of 14 new theatres, it is doubtful if the situation will improve as the theatres are located far away from the surgical beds. The number of theatres is also not adequate to meet the growing needs for operative work both in general surgery and specialised disciplines in this big hospital.

For the heavy load of surgical work in the Irwin Hospital, it will be difficult to improve upon the existing theatres. The Irwin Hospital should undertake general surgery work only. The high incidence of hospital cross infection is bound to continue so long as a proper central sterilise supply service is not organised. The Committee recommends that this should be done immediately.

The Lady Hardinge Hospital not only requires

an increase in the number of theatres but also complete reorganisation of this service to provide for piped gases and central suction, central sterile supply and recovery ward.

The Hindu Rao Hospital surgical unit for general surgery, gynaecology and maternity requires complete reorganisation.

The Committee recommends:

- (121) THAT THE ANAESTHESIOLOGIST SHOULD IN OVERALL CHARGE OF OPERATION THEATRE.
- (122) THAT THE NUMBER OF OPERATION THEATRES BE PROVIDED ON THE SCALE OF ONE THEATRE FOR EVERY 50 GENERAL SURGICAL BEDS. IN ADDITION, FOR SEPTIC WORK, EMERGENCY & ACCIDENT SERVICE, OUT-PATIENTS; GYNAECOLOGY, EYE, ENT & OTHER SPECIALTIES THERE SHOULD BE SEPARATE OPERATION THEATRES.
- (123) THAT BACTERIOLOGICAL EXAMINATIONS FOR STERILITY OF THEATRE AIR, EQUIPMENT, FLOOR AND FIXTURES SHOULD BE CARRIED OUT EVERY FORTNIGHT & PROPER RECORDS MAINTAINED.
- (124) THAT NEW OPERATION THEATRES SHOULD BE PLANNED BEARING IN MIND CLEAN AND DIRTY ZONES WITH AIR LOCKS AND SUITABLE ANCILLARY ROOMS FOR STORES AND SERVICES. SPECIAL ATTENTION SHOULD BE GIVEN TO REDUCE THE RISK OF CONTAMINATION.

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- (125) THAT OPERATION THEATRES SHOULD HAVE CENTRAL STERILE SUPPLY SERVICE & CENTRAL PIPED SYSTEM OF MEDICAL CASES AND CENTRAL SUCTION.
- (126) THAT RECOVERY ROOMS SHOULD BE LOCATED IN THE THEATRES BLOCK.
- (127) THAT ADEQUATE SAFETY MEASURES BE INSTALLED AGAINST FIRE AND EXPLOSION.
- (128) THAT ROUND THE CLOCK SERVICE UNDER THE CHARGE OF TRAINED OPERATION THEATRE TECHNICIAN SHOULD BE PROVIDED IN THE EMERGENCY THEATRE.
- (129) THAT THE WHOLE THEATRE BLOCK SHOULD PREFERABLY BE CENTRALLY AIR CONDITIONED WITH POSITIVE PRESSURE AND 100% FRESH AIR REPLACEMENT AND FILTERS WHICH WILL FILTER OUT PARTICLES MORE THAN 5 MICRONS. EACH THEATRE SHOULD BE EQUIPPED WITH GERMICIDAL ULTRA VIOLET LAMP. EACH OF THESE BLOCKS MUST HAVE ONE HIGH TEMPERATURE STERILIZER WHICH IS NOW AVAILABLE IN INDIA.
- (130) THAT THE DEFICIENCIES IN INDIVIDUAL HOSPITALS REFERRED TO ABOVE SHOULD BE ATTENDED TO.

Central Sterile Supply Department:

137. It is not necessary to emphasise the need of the Central Sterile supply Department, so essential in a large hospital. The fact that this

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is not in operation in most of the hospitals visited bears proof of lack of appreciation of one of the very important hospital services.

The Central Sterile Supply Department should be located at the ground/basement theatre floor with operation service, lifts, clean & dirty, leading to theatre floor above the central supply. The outgoing material will go out of the clean zone and the incoming equipment linen etc. will come to the dirty zone. From here it is cleaned and then sent for packing and sterilization. The Central Sterile Supply Department undertakes complete sterilisation of all material utilised by the hospital-wards and theatres and their proper dispensation to various services according to their need.

The Committee recommends:

- (131) THAT THE IRWIN, THE LADY HARDING AND THE HINDU RAO HOSPITALS SHOULD EACH HAVE A CENTRAL STERILE SUPPLY SERVICE.
- (132) THAT THE CENTRAL STERILE SUPPLY SERVICE IN THE GOVIND BALLABH PANT HOSPITAL SHOULD BE COMMISSIONED.
- (133) THAT IN ALL HOSPITALS BACTERIOLOGICAL STERILITY OF THE SUPPLIES FROM CENTRAL STERILE SUPPLY DEPARTMENT SHOULD BE CONSTANTLY AND REGULARLY CHECKED TO ENSURE PROPER QUALITY AND RECORDED.

Emergency and accident service:

138. The emergency and accident service is not fully geared in any of the hospitals in Delhi to meet the growing demands of the Matropolitan city. In view of the importance of this service, the Committee feels that a well organised and coordinated plan should be developed for the whole of Delhi. The details of such a plan are dealt with in the section on Coordination ( para 176 )

Hospital Infection:

139. The Committee considers that there is something basically deficient with sterilisation and investigative services which needs urgent improvement. It considers that the control of infection has not received due attention of hospital administrators.

The Committee recommends that each hospital should have a standing Committee for Prevention of Hospital Infection with the Chief of Surgery, the Chief of Medicine, the Chief of Microbiology Department and the Anaesthesiologist who would constantly and regularly review the position regarding sterilisation of equipment in the central sterile supply department, operation theatres, obstetrics and gynaecology and paediatric units. A major function of this Committee is to sponsor studies



from time to time on the prevalence of infection in the hospital, isolate the organisms responsible for the infection, determine the factors involved in the occurrence and spread of infection and on the basis of this evidence, take effective steps to control the infection.

The Standing Committee should receive at monthly intervals reports from various clinical units of the hospital regarding the frequency of infection in the respective units. It should investigate the reasons for the prevalence of infection and institute appropriate remedial measures.

To assist the Standing Committee in this work, each hospital should designate a sister as Infection Control Sister. Her duties consist of maintaining for each ward a register with entries of all septic complications with relevant clinical details. She collects and tabulates all cases of hospital infection. Swabs are taken from infected lesions as well as from suspected carriers and the material promptly despatched to the bacteriology Department for isolation of pathogenic bacteria. The report is sent to the Standing Committee to institute appropriate measures to deal with the infected case and other relevant material. Also see volume 2.

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The Committee recommends:

(134) THAT EACH HOSPITAL SHOULD HAVE A STANDING COMMITTEE FOR THE PREVENTION OF HOSPITAL INFECTION WITH THE CHIEF OF SURGERY, THE CHIEF OF MEDICINE, THE CHIEF OF MICROBIOLOGY DEPARTMENT AND THE ANAESTHESIOLOGIST TO MEET REGULARLY ONCE A MONTH AND REVIEW THE POSITION REGARDING HOSPITAL INFECTION AND EFFECTIVENESS OF STERILIZATION AND RECOMMEND MEASURES TO COMBAT INFECTION.

(135) THAT EACH HOSPITAL SHOULD HAVE AN INFECTION CONTROL SISTER TO ASSIST THE COMMITTEE.

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Medical Records

140. The Medical Records Department should keep on record the full details of every patient, from the time he enters the hospital to the time of his discharge or death as the case may be. The details so maintained should include all clinical notes, investigations and their results, treatment, progress and condition at the time of discharge and advice etc. These records are of great value for patient care evaluation and for future references. These may also be required in courts in litigations or other medico-legal proceedings. In teaching hospitals they form important material for research besides statistical investigation. In short, the medical records department is a vital link between the hospital and the public it serves.

For purposes of comparison, it is desirable that hospitals should have a uniform pattern of forms such as case sheets, requisition forms, charts, operation records, anaesthesia records, consultation records, progress notes, nurses daily record, intake output charts, diet sheets etc. Forms should be kept as simple as possible. It is, however, not essential to change the existing forms forthwith but they may be done progressively so that each hospital has the same type of forms for use

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in outpatients, in-patients and the diagnostic services.

The Committee observes that very little attention has been given to the space needed for the records department. It has to be appreciated that the medical records are valuable documents which have to be stored for long periods. Adequate storage space should therefore be planned for this department. A procedure for weeding out (after keeping a summary) should be laid down with due regard to the provisions of Indian Evidence Act and the Indian Limitation Act. The practice followed in the developed countries is to retain medical records for a period of 25 years following the last visit of the patient. The record is stored at the hospital level for the first six years and thereafter in less effective storage.

It is essential that all hospitals should maintain medical records systematically. It is desirable to organise some form of recording for out-patients.

The medical records department should develop a reference library which is kept open for at least 12 hours during the day with adequate staff.

The medical record library should have a photographic wing to facilitate preparation of documents.

The Medical Records Department in the Safdarjang Hospital is functioning on proper lines. In the Willingdon, the Lady Hardinge and the Hindu Rao Hospitals the medical records department should be organised on the lines, approved by the Government. For the unit in the Irwin Hospital to function satisfactorily the deficiency in respect of staff and space should be made up to the approved scale.

The Committee considers that a systematic maintenance of medical records, both for out patients and in-patients, is desirable. As trained records librarians /are few, it may be best to concentrate efforts initially on introducing inpatient recording system.

The Committee recommends:

- (136) THAT ALL HOSPITALS SHOULD ORGANISE ON PROPER LINES MEDICAL RECORDS KEEPING FOR INPATIENTS AND OUT-PATIENTS WITH QUALIFIED STAFF.

- (137) THAT THE FORMS USED IN HOSPITALS SHOULD BE STANDARDISED.

(138) THAT MEDICAL RECORDS SHOULD BE RETAINED FOR A MINIMUM PERIOD OF 25 YEARS FOLLOWING THE LAST VISIT OF A PATIENT. THE RECORD SHOULD BE STORED AT HOSPITAL LEVEL FOR THE FIRST SIX YEARS TO ENABLE INSTANT RECALL AND THEREAFTER MAINTAINED IN LESS EFFECTIVE STORAGE WHICH SHOULD ALLOW RECALL WITHIN 24/48 HOURS.

(139) THAT THE MEDICAL RECORD DEPARTMENT'S SHOULD DEVELOP A REFERENCE LIBRARY WHICH SHOULD BE KEPT OPEN FOR AT LEAST 12 HOURS DURING THE DAY.

(140) THAT MEDICAL RECORD SECTION BE STARTED IN WILLINGDON, LADY HARDING AND HINDU RAO HOSPITALS FORTHWITH.

(141) THAT THE DEFICIENCIES OF SPACE AND STAFF IN THE MEDICAL RECORD DEPARTMENT IN THE IRWIN HOSPITAL BE REMEDIED.

(142) THAT CENTRAL PHOTOGRAPHIC DEPARTMENT OF THE HOSPITAL SHOULD BE LOCATED IN THE MEDICAL RECORD LIBRARY.

Medical Audit (Patient Care Evaluation)

141. The Health Survey and Planning Committee (1959-1961) in its report suggested that medical audit should be encouraged in every hospital/institution. The Medical audit throws light on the standard of administration of the hospital, in-adequately equipped physical plant, lack of essential staff needed for

- o patient care, lack of competent supervisory personnel and deficient personnel policies affecting morale.

The Committee regrets to note that this measure which will ensure the practice of scientific medicine and serve as a specific check on the standard of professional work performed in the hospital, has not been implemented in any of the Delhi hospitals. The Committee recommends that each hospital should appoint immediately a Medical Audit Committee, with a Pathologist, a Surgeon, a Physician and a Medical Record Officer. The proceedings of this Committee's meetings will be confidential. A regular record of these proceedings should be maintained. This medical audit Committee, besides acting as a patient care evaluation cell will also be in a position to advise the Medical Records department to improve its working efficiency.

The other items which may be looked into by medical audit are:-

The average bed occupancy.

The average length of stay of a patient.

The gross results of patient care.

Consultations.

Infections.

Complications occurring in clean

Surgical cases, obstetric cases and

medical cases.

Unnecessary and incompetent surgery.

Autopsy rate.

Staff conference.

Death Conference.

The Committee recommends:

(143) THAT MEDICAL AUDIT COMMITTEE SHOULD  
BE SET UP FORTHWITH IN EACH HOSPITAL.

(144) THAT IN EACH HOSPITAL MORTALITY REVIEW  
SHOULD BE CARRIED OUT PERIODICALLY.

Compulsory Autopsy:

142. It has been suggested that hospitals should have power to undertake autopsy on the body of a patient who dies in the hospital, where considered necessary by the medical authorities, in the interest of efficient patient care and the advancement of science. Then the clinician will exercise due care in the treatment of his patients as any lapse on his part will be revealed at the autopsy.

The law recognises that the right of possession of a dead body belongs to those closely connected with the deceased by domestic ties, usually the surviving spouse or next of kin. If a body is dissected without consent, the bereaved person is entitled to recover all

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damages which are proximate and natural consequences of the wrongful act.

The right of post-mortem examination exists only if authorised by law or whenever the surviving spouse or next of kin of the deceased may otherwise agree for post mortom examination to ascertain the cause of death. Therefore, even taking consent for the patient for post-mortem examination in advance in the event of his death in the hospital will not be valied in law.

The Committee has also observed that the provisions of Corpners Act are not applicable to Delhi. No medical certificate is required before disposal of the body of a deceased. This is a very said state of affairs.

The Committee recommends:

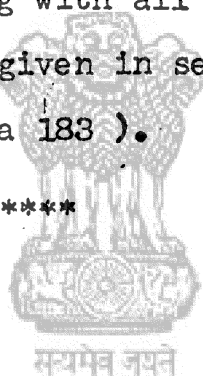
- (145) THAT GOVERNMENT MAY ENACT SUITABLE LEGISLATION TO ENABLE AUTOPSY TO BE PERFORMED.
- (146) THAT THE PROVISIONS OF THE CORONER'S ACT BE MADE APPLICABLE IN DELHI.

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Medicolegal:

143. Delay in disposal of dead bodies due to inadequate facilities of medicolegal post-mortems has been the main cause of complaint against this service. No separate staff is employed for medicolegal work and only a few numbers of the teaching staff of Medical Colleges have been authorised by Delhi Administration to perform such autopsies - A plan for dealing with all medico legal work in Delhi is given in section on Coordination (para 183 ).

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## Education and Training

### Medical Education:

144. While all major hospitals in Delhi participate in undergraduate and post-graduate education they are not adequately equipped or staffed for this task. Early action should be taken to staff and equip these hospitals to the requisite standards so that medical education does not suffer. Teachers with requisite experience, qualifications and standing should be employed. Necessary Physical facilities and equipment should also be provided. It would be better to abolish teaching of a particular discipline in a hospital where well qualified and experienced teachers in that discipline are not available and the necessary physical facilities and equipment are lacking.

### Continuing Education:

145. Continuing education of general duty medical officers in service and refresher courses for general practitioners are of paramount importance to maintain the efficiency of patient care. The Committee recommends that all specialists in these hospitals should organise special short term refresher courses and clinics for this purpose.

### Positive Health:

146. The modern hospital should not only render

efficient patient care but also promote the concept of positive health. It should no longer be content with activities aimed at restoration of impaired health but should actively participate in the field of promotion of health and prevention of disease. The hospital has to meet the challenge and demand a higher health status for the community it serves. The Committee is of the opinion that integration of preventive and curative medicine in medical and administrative practice at the hospital is overdue.

In large hospitals a Department of Preventive Medicine should be established under the leadership of an experienced specialist in preventive and social medicine whose function would be to spread the gospel of prevention of disease and promotion of positive health and to coordinate the preventive and curative activities of all the Departments of the hospital e.g. maternal and child health, social paediatrics and immunization programme. He should be directly responsible for the care of patients suffering from communicable diseases, public health activities, mental health, health education, nutrition and diet services in the hospital.

He should be in charge of general sanitation and prevention of introduction of infection into the hospital and the campus. He would be responsible for community health -

preventive and home care services. It should not be difficult in the teaching hospitals e.g. Maulana Azad complex, the Lady Hardinge and the A.J.M.S. to organise this Department. The Safdarjang, the Willingdon and the Hindu Rao Hospitals should have a social and preventive physician.

#### Health Education:

147. There is ample opportunity for health education to be carried out in hospital wards and out-patient departments. Because of the illness and the anxiety to keep well, the patients and their families are especially receptive to the advice of the doctors and nurses. The medical social workers and nurses should be responsible for this work. During the time the patients are waiting in the out-patient department for consultation, the waiting period can be put to good purpose by simple educational schemes using audio-visual aids. Social workers can stimulate the interest of groups of patients. Protection against prevailing communicable diseases by immunization could be a subject for health education to be followed by talks for protection against other current diseases.

The ultimate goal of health education is to help people attain, not just freedom from disease or infirmity, but a state of complete mental, physical and social well being. A major obstacle in

accomplishing a successful educational programme is that the concept of health education is new to many. Clinicians and hospital administrators have to be made aware of the usefulness of this programme.

Training of Hospital Administrators :

148. The importance of hospital administration in the fields of patient care, medical education and research has already been dealt with earlier. Abroad, more and more doctors, nurses and lay administrators are being trained in this subject in order to prepare them for their respective roles in hospital management. In our country, the facilities for such training are limited. In Delhi, a post-graduate course in Hospital Administration is available at the All India Institute of Medical Sciences. The National Institute of Health Administration and Education conducts staff colleges.courses.

The Irwin

Hospital runs orientation courses. It is necessary to enlarge the scope and capacity of these courses and introduce them in more institutions so that adequate numbers of medical, nursing and lay administrators can be trained. In addition to these it is necessary to arrange for orientation and refresher courses to enable medical

administrators to keep abreast of latest developments.

Training and continuing education of Para-Medical Personnel.

149. The Committee observes that one of the greatest difficulties experienced by hospitals is to obtain adequate number of Nursing and Daies skilled, Para-medical and technical staff. Shortage of staff in the radiological department or pathology laboratories causes delay in investigations. Inaccurate results are due to lack of sufficient technical skill or hurried work because of under-staffing. Lack of promotion prospects further aggravates the position as the available workers have no incentive. The same is the situation in respect of other categories of para-medical technicians and staff.

The Directorate General of Employment and Training (Ministry of Labour, Employment & Rehabilitation) has formulated a scheme for pre-employment training of Class III and Class IV hospital staff. This has been started as a pilot scheme in the Safdarjang hospital. The training is being imparted to nursing orderlies, hospital ayas, sweepers and sweepresses and assistants in operation theatres. The duration of the course for Class IV staff is 2 months and for Class III staff nine months.

The Committee considers that in addition to continuing this training programme for

para-medical staff, the Government should review the conditions of employment, including promotion prospects in order to attract to and retain within the service, the intelligent young men and women needed to fill these vital posts.

Lack of proper orientation of the hospital staff to the organic development of hospital service contributes substantially to the low efficiency in Delhi hospitals. Para-medical staff, the mainstay of hospital organisation, needs proper orientation to meet the growing requirements of hospitals. The adoption of new working methods and new equipment and the development of new disciplines call for continuing in service training and education of the hospital staff if they are to discharge their functions with confidence and efficiency.

#### Nurses Training

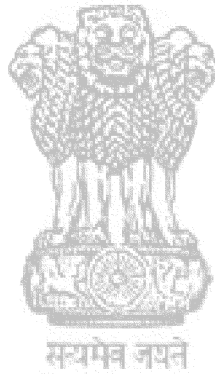
150. The training of general nurses has already been dealt with in para 130. With the development of more and more special disciplines the necessity for specially trained nurses has arisen. The Committee therefore recommends that facilities should be established for training of nurses in disciplines like psychiatry, paediatrics, cardiology, cardiothoracic neuro surgery etc.



The Committee recommends:

- (147) THAT THE REQUIREMENTS OF STAFF, PHYSICAL FACILITIES AND EQUIPMENT OF TEACHING HOSPITALS SHOULD BE BROUGHT UP TO THE STANDARDS FOR PURPOSES OF MEDICAL EDUCATION.
- (148) THAT SPECIAL SHORT TERM REFRESHER COURSES AND CLINICS BE ORGANISED IN THESE HOSPITALS FOR GENERAL DUTY MEDICAL OFFICERS AND PRACTITIONERS.
- (149) THAT A DEPARTMENT OF PREVENTIVE MEDICINE SHOULD BE ESTABLISHED IN EACH HOSPITAL.
- (150) THAT THE PREVENTIVE AND SOCIAL PHYSICIAN SHOULD COORDINATE THE HEALTH EDUCATION AND PREVENTIVE HEALTH ACTIVITIES WITH THE CURATIVE PROGRAMME.
- (151) THAT HEALTH EDUCATION FACILITIES SHOULD BE AVAILABLE IN OUT-PATIENTS OF THE HOSPITAL AND THAT AN ADEQUATE NUMBER OF MEDICAL SOCIAL WORKERS SHOULD BE AUTHORISED FOR THIS PURPOSE.
- (152) THAT GOVERNMENT SHOULD GIVE EARNEST CONSIDERATION TO AUGMENT FACILITIES FOR TRAINING OF MEDICAL, LAY AND OTHER HOSPITAL ADMINISTRATORS.
- (153) THAT ORIENTATION AND REFRESHER COURSES THROUGH WEEK END OR SHORT DURATION SEMINARS BE ORGANISED BY INSTITUTIONS LIKE NATIONAL INSTITUTE OF HEALTH ADMINISTRATION AND EDUCATION (NIHAE).

- (154) THAT IN SERVICE TRAINING AND ORIENTATION SHOULD BE IMPARTED IN ALL HOSPITALS TO ALL CATEGORIES OF HOSPITAL STAFF RELEVANT TO THEIR RESPECTIVE FUNCTIONS IN THE HOSPITAL.
- (155) THAT ARRANGEMENTS BE MADE FOR TRAINING NURSES IN SPECIAL DISCIPLINES.



Medical Staffing

157. The medical staff of the Willingdon, the Safdarjang and the Hindu Rao Hospitals for clinical, para-clinical and administrative functions consists of

	<u>Willingdon Hospital</u> (552 beds)	<u>Safdarjang Hospital</u> (1148 beds)	<u>Hindu Rao Hospital.</u> (331 beds)
Consultant (1800- (Super time 2250)	2	2	-
Professors (1300- (Super time 1800)	-	1	-
Specialists (600- 1300)	13	48	20 (13 + 7*) *Junior Staff Surgeon
GDOs	35	58	28
Registrars	19	64	3 (under sanction)
Housemen	34	110	10

The A.I.I.M.S., Hospital, the Lady Hardinge and the Irwin Hospitals form part of the College complex and therefore have common staff both for teaching and clinical work. The heads of departments are in the professorial grade, assisted by assistant professors and lecturers in the specialist grade. The Principals of the institutions are in the scale of supertime Grade-I and have additional teaching and clinical responsibilities.

The G.B. Pant hospital, which has certain special disciplines has a number of consultant posts (super time Grade I) as Chiefs of units e.g. consultants in Cardiology, Cardiac Surgery, Neurology, Neuro-surgery.

It will be seen from the above that hospital posts in different specialities and units are tenable in different grades, viz., super time Grade-I (Rs. 1800-2250); supertime Grade II (Rs. 1300-1800) and specialist (Rs. 600-1300).

The Superintendents of the Willingdon and Safdarjang Hospitals are in the super-time Grade-I. They are also consultant in their own specialities. In all, two posts of consultants, one in medicine and the other in surgery, are sanctioned in each of these hospitals. The post of superintendent is out of these. The post of consultant in medicine in the Safdarjang Hospital has been vacant for about three years.

As referred to above the Irwin and the Lady Hardinge teaching hospitals have clinical posts in a scale higher than that of specialists, viz., professors in the different disciplines. There are no such posts in the two Central Government hospitals viz. the Safdarjang and the Willingdon (except of an anaesthetist in the Safdarjang Hospital). Specialist

and the next lower  
posts of specialist

cover in these hospitals is mainly provided by doctors who possess postgraduate qualifications and are posted as staff surgeons or junior staff surgeons on specialist's scale of pay. Thus, there is a considerable gap between the senior posts of consultants in these hospitals. In their day to day working these specialists are assisted by GDOs, registrars and housemen.

The basis of medical staffing is not clear. The Safdarjang hospital has a proportionately larger number of posts in all categories than any other hospital. The G.B. Pant Hospital has a number of consultant posts in the scale of Rs.1800-2250 and this has created an anomaly in the Maulana Azad Complex where the professors are in the supertime Grade-II. The inequity of higher status and importance given to specialists in limited fields as compared to the heads of departments of wider disciplines like medicine and surgery has undermined the morale of the latter and given rise to legitimate grievance.

The present staffing of the Hindu Rao Hospital with only a few Junior Specialists without registrars in the different units is not at all satisfactory.

Honorary system

152. The honorary system exists only in the Irwin Hospital where 37 honorary doctors are on the staff. Though this system has not found favour in all quarters, as it will not be possible to meet the requirements of teaching and medical relief with full time staff, the employment of honorary doctors for part time duties is in-evitable. However it should be ensured that fully qualified and experienced doctors are engaged in this capacity and that they are subject to the same rules and regulations as the paid members.

Emeritus Consultants

153. Daily visits to the hospital by Emeritus Consultants appears to be causing embarrassment to the Heads of the respective departments. These consultants should restrict their visits to occasions when their advice is sought by the hospital staff.

154. It is noticed that in the employment of doctors in higher grades professional experience in addition to postgraduate qualification does not receive the emphasis it should. It must be appreciated that mere possession of postgraduate qualification cannot be the sole criterion for selection of a specialist to take personal responsibility for the complete medical care of all patients in his speciality.

The Willingdon and the Safdarjang hospitals should also have the services of

doctors of certain standing in super time Grade II in the same way as in the other teaching hospitals. The total responsibility in all specialities except in medicine and surgery in these two hospitals vests with young doctors. Many specialities have more than one specialist. All of them are now of the same status which is not at all conducive to efficiency in medical care or discipline. Absence of posts below the consultant status has deprived the two hospitals of the services of specialists of standing. Whenever their turn came for promotion, they had to be transferred out to other institutions. There has thus been a continuous drain of experienced hands in the last few months, leaving the specialities in the hands of less experienced persons.

The Committee is of the firm view that the consultant grade posts of Rs. 1800-2250/- should be selection posts and should only be available for senior officers by virtue of their qualification, experience, and seniority and not linked with posts in particular disciplines. There should be posts in supertime Grade II (Professors scale) in the different specialities in the Willingdon and the Safdarjang Hospitals as in the Irwin and the Lady Hardinge hospitals.

155. General Duty Medical Officers should be employed in hospitals only to the extent medical officers in service are seconded to these institutions for post-graduate studies. The rest of the intermediate posts should be converted into those of registrars (with postgraduate qualifications) who should be in residence in the campus and be appointed for a tenure of 3 years. They should be given responsible work in each unit including, in surgical specialities, some of the simpler operative work without immediate personal supervision.

Post-graduate students, not in service, should be required to stay in the hospital campus as resident staff and be designated as residents.

156. The staffing pattern of the casualty department is the most unsatisfactory feature in the present hospital staffing system. The consultant's supervision is practically non-existent

and, where it exists, it is purely nominal. In the committee's view the first principle in the staffing of the casualty department should be that one or more consultants on duty as per roster have the specified responsibility for casualty work for the day. A definite part of their time should be allotted to its supervision. The seniors should be available to assist the juniors in difficulties and bear the patient care responsibility. The casualty medical officers should have postgraduate qualifications and should be posted by rotation.



The Committee recommends:

- (156) THAT QUALIFIED AND EXPERIENCED PERSONS ONLY BY APPOINTED AS SPECIALISTS.
- (157) THAT THE SUPERTIME GRADE I POSTS IN THE SCALE OF Rs. 1800-2250 AT G.B. PANT HOSPITAL SHOULD BE PLACED IN THE GENERAL POOL AND SHOULD BE FILLED BY SELECTION BY VIRTUE OF QUALIFICATION, EXPERIENCE AND SENIORITY; AND THE HEADS OF DEPARTMENTS/UNITS IN THE G.B. PANT HOSPITAL SHOULD NORMALLY BE IN SUPERTIME GRADE II, PROFESSIONAL GRADE.
- (158) THAT THERE IS A NEED FOR SPECIALISTS IN THE PROFESSIONAL GRADE (SUPERTIME GRADE II) IN THE WILLINGDON AND THE SAHDARJANG HOSPITALS IN EACH SPECIALITY EXCEPT THAT WHERE IN A PARTICULAR SPECIALITY THE WORK LOAD IS NOT HEAVY, A COMMON SPECIALIST IN THAT GRADE MAY LOOK AFTER THE WORK IN BOTH THE HOSPITALS.
- (159) THAT THE DIFFERENT DEPARTMENTS BE STRENGTHENED BY APPOINTMENT OF REGISTRARS WITH POST-GRADUATE QUALIFICATIONS ON A TENURE BASIS OF 3 YEARS.
- (160) THAT THE POST-GRADUATE STUDENTS REGISTERED FOR STUDIES SHOULD BE GIVEN PATIENT CARE RESPONSIBILITY AND BE DESIGNATED AS "RESIDENTS".
- (161) THAT THE NUMBER OF POSTS OF GENERAL DAY MEDICAL OFFICERS IN THE HOSPITALS SHOULD BE REDUCED TO THE MINIMUM TO GIVE OPPORTUNITIES TO GAIN EXPERIENCE.
- (162) THAT THE CASUALTY DEPARTMENT SHOULD FUNCTION UNDER THE DIRECT SUPERVISION OF THREE

DIFFERENT OFFICERS MEDICAL, SURGICAL AND MEDICO-LEGAL, AND THE RESPONSIBILITY OF PATIENT CARE SHOULD DEVOLVE ON THE HEAD OF THE UNIT CONCERNED. THE EMERGENCY SERVICE SHOULD BE MANNED BY EXPERIENCED MEDICAL OFFICERS WITH POSTGRADUATE QUALIFICATIONS.

- (163) THAT WHERE THE HONORARY SYSTEM IS ADOPTED, \_\_\_\_\_ THE DOCTORS SELECTED SHOULD BE FULLY QUALIFIED AND EXPERIENCED AND SHOULD BE SUBJECT TO THE SAME RULES AND REGULATIONS AS THE PAID MEMBERS.
- (164) THAT THE EMERITUS CONSULTANTS SHOULD VISIT HOSPITALS ONLY WHEN CALLED IN CONSULTATION BY THE HOSPITAL STAFF.

#### Operational Research

157. Operational research has been defined by the British Standards Institution as

"the application of scientific, analytical, experimental or quantitative data to industrial and business problems with the objective of providing a more analytical basis for making predictions."

The above definition limits the application of operational research to industrial and business problems. This can however be applied to the medical field, in particular to the organisation of hospital service, in order to make the best.

use of resources. Operational research would involve principally the collection of objective data on the day to day work of hospitals and their staff either as a routine or on ad hoc basis. Only rarely it would involve the use of complicated mathematical or statistical techniques.

The methods of operational research are the use of routine statistics, the technique of patient care, evaluation, work study and other ad hoc studies. It should be taken step by step, starting with simple analysis. For all this good medical and administrative records are necessary. It would be more useful to have community study to see how the population use hospital facilities. The services of institutes like NIHA & ICMR may be utilised.

The Committee recommends:

(163) THAT OPERATIONAL RESEARCH TO MAKE THE MOST EFFECTIVE USE OF AVAILABLE RESOURCES IN TERMS OF BEDS AND MANPOWER BE CARRIED OUT

(166) THAT WORK STUDY UNITS SHOULD GO INTO THE STAFFING PATTERN (OTHER THAN MEDICAL) IN HOSPITALS.

### Medical Negligence

158. The Committee has thought it desirable to refer to medical negligence which has been assuming increasing importance and in consequence receiving more and more attention the world over in recent years. Medical negligence, malpraxis or mal-practice is a term, usually applied to the failure of a doctor to exercise a reasonable degree of care and skill in the treatment of his patient. In other words, it is a failure on the part of the medical practitioner to perform his duty in his professional relation to the patient; a failure which results in injury to the patient. Thus, malpractice has two essential parts - first when the medical practitioner fails to do his duty and second, that definite injury to the patient as the result of his failure. Civil malpractice is a negligence arising out of failure to perform professional duties or the service of professional skill. The patient claims monetary remuneration - "money damages" - for injuries sustained through the negligence of the medical practitioner.

But before the duty arises, there must exist the relationship between doctor and patient. A doctor will be liable for negligence only when he has undertaken to treat a person. In his treatment a doctor is expected to exercise a reasonable degree of care and skill.

what is reasonable skill, depends on the  
circumstances in which the practitioner finds  
 himself. A general practitioner should be  
 reasonably skillful in all branches of medicine  
whereas a specialist should be particularly  
skillful in his speciality. But the skill  
 required, in accordance with general  
 principles, will be that of an average  
 specialist, but not that of an exceptionally,  
 able and gifted one.

The hospital is held liable for the acts of  
all those in whose charge the patient was.

Medical research and experimentation on new lines  
 of treatment is not free from risk. The guiding  
 principle for a clinician who undertakes a trial  
 of a new treatment is for him to ensure that  
 three requirements are satisfied - voluntary  
 consent of the subject, prior animal experimen-  
 tation to investigate possible dangers to be  
 encountered and proper medical protection  
 and management during the experiment.

To prevent malpractice action, the  
 Committee recommends;

(167) THAT DOCTORS WORKING IN DELHI HOSPITALS  
 SHOULD BE ASKED TO PURCHASE PHYSICIAN'S  
 LIABILITY INSURANCE, CALL MEDICAL  
 INSURANCE. THE PHYSICIANS' LIABILITY

POLICY IS A CONTRACT, WHEREBY AN INSURANCE COMPANY AGREES TO INDEMNIFY THE DOCTOR NAMED IN THE POLICY AGAINST LOSS BY REASON OF LIABILITY IMPOSED ON HIM BY LAW ON ACCOUNT OF BODILY INJURIES SUSTAINED, OR MISTAKE IN RENDERING OR FAILING TO RENDER PROFESSIONAL SERVICE IN THE PRACTICE OF HIS PROFESSION.

- (168) THAT HOSPITAL STANDING ORDERS DEFINING THE DUTIES OF EACH OF THE EMPLOYEE IN THE HOSPITAL SHOULD BE FRAMED IMMEDIATELY.
- (169) THAT QUALIFIED AND EXPERIENCED PERSONNEL BE APPOINTED TO ALL SPECIALITIES.
- (170) THAT A COURSE OF LECTURES ON MEDICAL NEGLIGENCE MAY BE ARRANGED PERIODICALLY FOR ALL THE STAFF OF THE DELHI HOSPITALS BY THE RESPECTIVE SUPERINTENDENTS.

4.2.

COORDINATIONGeneral:

159. Because of the multiplicity of authorities controlling hospitals in Delhi no coordination exists among them. This is so even among different institutions run by the Ministry of Health which are more or less independent units as illustrated by the working of the Willingdon and the Safdarjang Hospitals. There is a tendency to multiply similar specialities in several institutions instead of concentrating them in one or two places, and developing them fully so that people can get the best possible service. Scant consideration has been given in deciding the location of the hospitals, their size and scale of facilities and services. In certain areas even the basic minimum facilities for medical and surgical care do not exist. The growth of hospital service has been haphazard.

As referred to in a previous chapter, certain hospitals are deficient of equipment, and of technical, medical and para-medical personnel. The standard of patient care services varies from hospital to hospital. In the Hindu Rao hospital with a busy OPD, there is practically no accommodation and the laboratory service is nothing more than a

clinical side room, while another institution has a huge block exclusively for OPD and has a full complement of staff and equipment to undertake all diagnostic work. Patients naturally prefer to go to a hospital equipped to provide a higher standard of service, even if they have to travel a long distance.

Hospitals lacking facilities do not inspire confidence among the patients. The Committee understands that a substantial proportion of patients moves from one hospital to another in search of better treatment thereby causing infructuous expenditure on investigations and other services.

160. The Committee has thought it desirable to devote special consideration to the problem of coordination partly because some parts of Delhi have no hospital facilities at all and partly because some hospitals as they exist do not have the essential facilities to render satisfactory service. To have some uniformity in the basic minimum hospital care, the Committee is convinced that there must be a common authority for planning, standardisation, appraisal and coordination. The Committee does not envisage upsetting the present administrative arrangements for medical care and having a unified Central Control of all



hospitals. The different institutions can continue to be administered by the existing authorities but at the same time certain common services should be developed and organised on regional level. This Central authority will, in addition to laying emphasis on uniformity in the scales of accommodation, staffing pattern, equipment and ancillary services etc. for general medical care in different hospitals, also ensure distribution of beds on an equitable basis to all parts of Delhi. It will also see that higher sophisticated specialist services are not duplicated and encourage the development on a rational basis of services like emergency and accident service, blood bank, central workshop etc.

The Committee is convinced that re-organisation and coordination on the above lines can be brought about, provided, there is a will to accomplish. The biggest hurdle is the emotional and psychological attitude and the reluctance of people to rise to the occasion. All the controlling authorities of hospitals in Delhi should be prepared to cooperate with and authorise the Central authority to formulate policies and plans for the greater good of the beneficiaries of the hospital and health services.

The Committee considers that improvement of services is possible only when a fully coordinated programme for the whole of Delhi is implemented. The planned development of such a hospital service on a regional basis is discussed in the later part of this chapter. However, the coordination in the working of existing hospitals in general and of certain specialised services in particular is absolutely essential to effect improvements in the present hospital situation. The minimum programme in this direction which the Committee considers as feasible and practicable is to have at least close collaboration and coordination among the Government hospitals. They should function as complementary to each other.

161. For the last 5 years a Coordination Committee of the Superintendents of all hospitals, Central, State, local authorities, voluntary and private, has been functioning sporadically under the chairmanship of the Director General of Health Services. The intention was to bring closer collaboration and coordination in the working of these hospitals. So long as the proposed Regional Health authority is not set up this committee has to be given a definite status. It must meet regularly to discuss problems of common

interest. It is too much to expect the Director General to effectively coordinate the functioning of these hospitals. The Committee therefore considers that in the Directorate General of Health Services a Bureau of Medical and Hospital Services under the charge of a Deputy Director General should be organised to coordinate the activities of different hospitals in the country in general and in Delhi in particular.

Integration of the Safdarjang & the A.I.I.M.S.

162. During the course of the deliberations of the Committee, the desirability of integration of the Safdarjang and the A.I.I.M.S. hospitals came up frequently for discussion. The Committee had the benefit of the advice of the Superintendent, Safdarjang Hospital and the Director and senior staff of the Institute separately and collectively. The A.I.I.M.S. Hospital does not have sufficient facilities for training all under-graduates as this hospital with 750 beds cannot have necessary clinical material for under-graduates as also keep apart beds for higher specialities for post-graduate students and research. The Safdarjang hospital with over 1100 beds and about 2000 daily out-patients attendance provides good clinical material. This hospital also has a fine Accident

and Emergency Service, Burns and Plastic Unit and a National Orthopaedic Institute. There seems to be no justification for denying the medical students this useful clinical material at the Safdarjang Hospital. By Admitting routine medical and surgical cases in the A.I.I.M.S. hospital for undergraduate students the number of beds for the higher specialities is reduced. The Institute certainly needs an increase in beds specially as it has to develop many specialities and super-specialities for the proper training of post-graduates.

163. The Committee is fully convinced that much closer collaboration between the two sister hospitals across the road is not only desirable but essential. In the evidence before the Committee there was near unanimity for complete amalgamation of the two hospitals under one Director with a number of administrative deputy directors to look after the different functions. The senior officers of the institute have recommended the entire take over of the Safdarjang Hospital as part of the Institute including the C.G.H.S. specialist service with the provision that separate staff will man the C.G.H.S. specialist service and only selected referred cases will be seen by the consultant staff; and that the nursing home facilities

for C.G.H.S. will continue to remain at the Willingdon Hospital as at present. The Director of the Institute is of the opinion that the Institute should not take on the responsibility of the C.G.H.S. work even if separate staff is appointed for that purpose. In his view, it would mean so much increase in the work of the Faculty staff that their research and teaching activities will suffer.

164. The Committee considers that there is a strong case for the unification of the AIIMS and the Safdarjang hospital into a single medical complex. The take over should be complete including the work of the C.G.H.S. The details of the type of specialities to be located in each campus, rationalisation of departments to avoid duplication, stream-lining of services and employment of staff will have to be worked out of the two institutions. The Ministry of Health, Family Planning and Urban Development will have to surrender the control of the Safdarjang Hospital to the autonomous A.I.I.M.S.

Maulana Azad Medical Complex:

165. The position in the Irwin Hospital and the G.B. Pant hospital is similar to that in the A.I.I.M.S. and the Safdarjang hospitals.

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The two institutions must be integrated with Maulana Azad Medical College in the interests of efficiency and economy and placed under one unified control, namely, that of the Director-Principal of the Maulana Azad Medical College. The two hospitals under the Director-Principal can have separate superintendents who will help him in the general administration of the hospitals. In the internal administration of the Irwin and the G.B. Pant Hospitals it is observed that there are more than one controlling power which is not conducive to efficient running of any institution. The Committee suggests that a small committee of various authorities concerned with these hospitals and the College should be appointed to plan details of integration of these institutions. As long as this not done, it is doubtful if these hospitals will ever attain the standards expected of them.

#### Functional Integration:

166. As has already been discussed it will be necessary for the administration to restrict certain types of investigations and therapy to specific hospitals in Delhi. For this purpose the Willingdon Hospital should be functionally integrated with the Lady Hardinge Medical College Hospital for purpose of histopathology and other morbid anatomy work, the Hindu Rao

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Hospital should be integrated with the <sup>M</sup>Maulana Azad Medical College and the Safdarjang Hospital with the A.I.I.M.S. For teaching of students of the <sup>L</sup>Lady Hardinge in the Willingdon Hospital it would be better to have greater functional integration.

The Committee recommends:

- (171) THAT THERE SHOULD BE INTEGRATION OF THE A.I.I.M.S. HOSPITAL AND THE SAFDARJANG HOSPITAL UNDER ONE MANAGEMENT.
- (172) THAT THE DETAILED SCHEME FOR THE DEPLOYMENT OF PERSONNEL, LOCATION OF SPECIALITIES ETC. SHOULD BE WORKED OUT BY A HIGH POWER COMMITTEE CONSISTING OF EXPERTS FAMILIAR WITH THE WORKING OF THE TWO INSTITUTIONS.
- (173) THAT THERE SHOULD BE INTEGRATION OF THE MAULANA AZAD MEDICAL COLLEGE, THE IRWIN HOSPITAL AND THE G.B. PANT HOSPITAL UNDER ONE MANAGEMENT FOR SERVICE, EDUCATION AND RESEARCH.
- (174) THAT THE WILLINGDON HOSPITAL SHOULD SERVE AS A CLINICAL CENTRE FOR TEACHING OF STUDENTS OF THE LADY HARDINGE MEDICAL COLLEGE AND THAT THE STAFF & PHYSICAL FACILITIES OF THIS HOSPITAL SHOULD BE BROUGHT UP TO THE REQUIRED TEACHING STANDARD.

Planned Development of Specialities:

167. It has to be conceded that no single institute can develop all the specialities on an equitable basis nor is it desirable to do so. At present there is a tendency for all the Delhi Hospitals to develop as many specialities as possible irrespective of their needs. This is particularly unworkable because of -

- (a) lack of finances for adequately equipping such units and providing accommodation in various hospitals; and
- (b) lack of adequately trained personnel.

This has resulted in half baked specialist Units which are unable to serve the public efficiently and a good deal of frustration amongst the staff of such units. This can be seen in the G.B. Pant Hospital and the A.I.I.M.S. It will, therefore, be necessary to formulate definite plan for developing such specialities. Since these have to be developed around trained and capable men, the selection of hospitals should be around such people.

168. The Safdarjang Hospital has very good Casualty Services and Burns and Plastic Surgery Units. The administration should help the Safdarjang Hospital to develop these to a point when they will be able to render excellent services to all patients requiring such care



and also be a training centre for these specialities.

169. The A.I.I.M.S. is developing Neurology and Neuro-Surgery, Cardiology and Cardiovascular Surgery, Genito-urinary Surgery, Endocrinology and Gastro-enterology. This institution of National importance should be encouraged to develop these specialities so that they are not only able to cater to the public requirements but also be the real centre for training of post-graduates in these specialities.

170. The Maulana Azad Medical College Complex has a nucleus of Dermatology, Neurology, Neurosurgery, Gastro-arterology and Cardiology and Cardio-thoracic Surgery. Since these specialities need to be developed in more than one hospital in Delhi this should be fully developed in the Maulana Azad Medical College Complex. The Willingdon Hospital should not attempt to specialise in any one of these branches apart from Cardiology. It will be reasonable to expect this hospital to develop into a good general hospital for the care of patients. The only speciality that needs to be developed is Cardiology.

171. The Lady Hardinge Hospital should specialise in diseases of both women and children. This is

particularly relevant since this hospital has already the nucleus of a large children's hospital in Kalavati Saran Children's Hospital.

#### Coronary Care Unit:

172. With the increasing incidence of heart disease the need for a coronary unit is felt. A coronary Care Unit can be expected to make the maximum impact on mortality from myocardial infarction if admission is restricted to patients within 48 hours on onset of symptoms and to those who later develop serious arrhythmias while being treated elsewhere. The construction, equipment and particularly the staffing requirements make the establishment of this unit an impracticable proposition in the majority of the hospitals. The Committee considers that such a unit is essential in the Willingdon Hospital and the two teaching institutions viz., the All India Institute of Medical Sciences and the Maulana Azad Complex.

A 4-6 room Coronary Care Unit is considered adequate. The set up is that each room is acoustically insulated from its neighbour ensuring privacy and quietness and allowing protection of patients from crises from adjacent rooms. Double glazed windows provide close observation of each room a Central monitoring bay.

In each room there is a Sanborn 'Visomonitor' with built-in pacemaker, an oscilloscope, and a memory tape. The monitor, which has a rate-activated alarm, produces visual alarms in the patient's room and both Visual and auditory alarms at the central station. A ten second sample electrocardiogram (E.C.G.) is automatically recorded every fifteen, thirty, or sixty minutes, as required, and also whenever an alarm occurs. Piped Oxygen and suction points are mounted on the wall by the patient's head, and for intravenous infusions a movable pole hangs from the ceiling. The central station is mounted on an observation platform, and has six remote monitors and an oscilloscope for display of the E.C.G. from any one of the six rooms. Further equipment includes two D.C. defibrillators, a battery-operated pacemaker, a "Bird" respirator, a portable X-ray image intensifier for insertion of pace-making catheters, and equipment for endotracheal intubation.

Staffing requirements are very heavy. The patient in the Unit is solely in the charge of a consultant. The registrar and other house staff are specifically appointed to the unit. At night the duty doctor sleeps in the adjoining room so that there is a doctor present within

the unit at all times. The nursing staff is provided from a pool of ten nurses. One fully qualified and one senior trainee nurse are present at any one time. The value of the Coronary Care Unit largely depends on the medical and nursing staff.

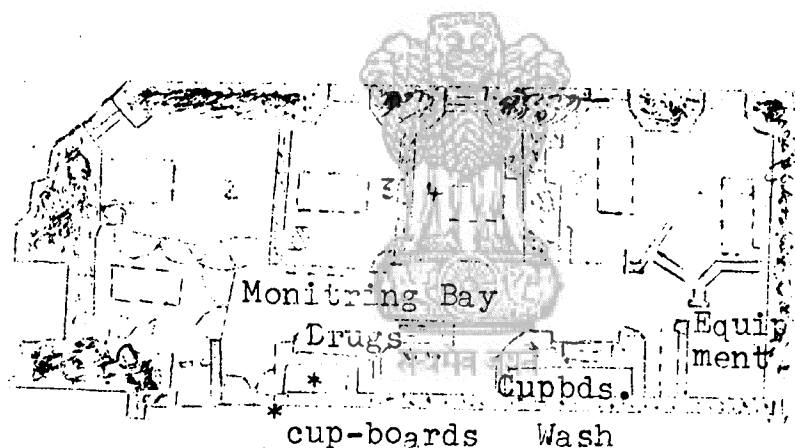


Diagram of Coronary - Care Unit.

The unit was constructed from an existing part of the hospital and the thicker black ( & dotted) lines represent supporting walls. The doctor's bedroom, office, and washroom are not shown.  
( Architect, Mr. A.A. Dixon.).

### Radio-therapy:

173. Radio-therapy is another field in which a lot can be done by developing such units in two or three hospitals instead of frittering away the limited resources by trying to develop such units in every hospital. This will not only enhance the existing facilities in the Delhi area but will enable each of these hospitals to collect adequate scientific data on cancer which is badly lacking in the country. For proper treatment, it is essential to have a proper follow up and recording system which must be introduced in these hospitals so that 80 to 90 percent of their patients can be followed up adequately to find out the effectiveness of one type of therapy or the other (see para. 124 also).

### Central Purchase<sup>0</sup> Organisation:

174. This will be another field for cooperation. Details of the plan are in para. 108.

175. Central workshop facilities - This also can best be developed for the Region rather than for each hospital. para. 112 refers.

The Committee recommends:

- (175) THAT WHILE THE SPECIALITIES OF GENERAL SURGERY, MEDICINE, OBSTETRICS AND GYNAECOLOGY, EYE, EAR NOSE AND THROAT SHOULD BE AVAILABLE IN ALL GENERAL HOSPITALS, IN THE INTEREST OF ECONOMY CERTAIN SPECIAL DISCIPLINES SHOULD BE DEVELOPED ONLY IN SELECTED HOSPITALS ON REGIONAL BASIS.
- (176) THAT IN FUTURE THE LOCATION OF A SPECIALITY IN ANY HOSPITAL SHOULD BE ON THE RECOMMENDATIONS OF THE TECHNICAL COMMITTEE OF THE REGIONAL BOARD.
- (177) THAT CORONARY CARE UNIT PROPERLY EQUIPPED AND ADEQUATELY STAFFED IN ACCORDANCE WITH RECENT CONCEPTS SHOULD BE ESTABLISHED IN THE THREE COMPLEXES VIZ. LADY HARDINGE / WILLINGDON; A.I.I.M.S./ SAFDARJANG AND THE MAULANA AZAD GROUP.

Emergency & Casualty Service:

176. The emergency and accident service in Delhi Hospitals has not kept pace with the growing demand of this Metropolitan city arising out of growing population, rapid industrialisation and urbanisation, high speed vehicular traffic, use of synthetic materials in day to day life etc. etc. Considerable effort has to be put into the field of emergency care.

Further vigorous steps are required to be taken to make it an efficient service. The weakest link has been lack of coordination. The emergency and accident service has therefore to be organised and coordinated at a central level.

177. The Committee recommends that for Delhi, scattered as it is with varying hospital facilities, there should be a Central Control Room for emergency cases. Such a control room should centralise the ambulance service with at least three sub-stations in three other areas. The ambulances will be fitted with walkie-talkie telecommunication sets so that the control room is in constant touch with the ambulances on road.

It should be able to provide

- (a) prompt ambulance service to patients,
- (b) Advise patients to be sent to the most suitable hospital for his treatment; and
- (c) Provide for emergency treatment in the ambulance.

Such a Central Control Room will ensure prompt attention to emergency cases. It will also be able to direct patients to go to the particular hospital where their ailments can

be best treated and where beds will be available on arrival. The Control Room will be able to alert the hospital concerned simultaneously of the nature and number of casualties being sent to them for immediate attention.

178. The emergency and accident department in the hospital will immediately inform by telephone the central control room of the name and address of any person admitted into the hospital to enable control room to answer all queries from anxious relatives.

The Hindu Rao, the Irwin, the Lady Hardinge, the Willingdon and the Safdarjang Hospitals should be properly equipped and staffed to handle all accidents and emergency cases.

The Emergency department should have a ward attached with all facilities for resuscitation, operative and diagnostic work.

179. There is only one well developed burns unit in Delhi, the one in the Safdarjang Hospital. This is not enough to cater to the needs of the whole of Delhi. Another unit should be established in a hospital in central Delhi.

180. Traumatic Surgery Unit for head injury should be properly organised and developed in



all major hospitals which admit accident cases.

181. To cater for any major catastrophe every hospital should have a Disaster Plan laying down details of utilization of both space and personnel. Multi-discipline facilities will be required simultaneously and concurrently. The hospital should have a Trauma Team under the leadership of the general Surgeon, consisting of various specialists and specialised personnel. Emergency posts should be assigned to each member of the hospital staff. Even in peace time the more common day to day catastrophe - accidents and serious burns cases - requires prompt attention. They do tend to disorganise facilities and the routine of the institutions if the hospital is not well prepared and trained in advance for this work.

All major hospitals must be prepared to treat and care for the victims of the disaster regardless of the number of persons involved and it should be planned in such a way that the plan is put into operation without loss of time when needed.

#### Central Blood Banks

182. The Committee has observed that Hospital Blood Banks are mainly dependent on paid donors

drawn from a stratum of society which could ill-afford to donate blood and yet offer to sell blood for a nominal price. It is important that in a town like Delhi, the seat of the Central Government, teeming with intelligentia, the spirit of service and social values are so sadly lacking that it is not possible to raise sufficient volunteer donors from among those who are better equipped physically to donate blood - a social service so harmless to the donor, yet so valuable to the recipient. Every effort should be made now to raise volunteers for this purpose. The Committee recommends the establishment of a well-equipped and staffed Central Blood Bank in Delhi to supply blood to all local hospitals.

183. The Central Blood bank will collect blood from donors at the centre and in various camps in and around Delhi. Sufficient quantities of blood of various groups and rare groups can be collected and dispensed to the various Institutions on "No profit no loss" basis. This will require creating an organisation with multiple functions. Mobile collection teams, central registration and documentation of the blood collected, recording of rare blood groups, maintenance of panels of donors,

dissemination of knowledge regarding the functions of the blood bank and collection of blood from various institutions and offices in and around Delhi are some of the many functions of such a Central Bank. This is a type of service which is essential and very often life saving and yet there is general apathy to this very important need of the hospitals which are now woefully dependent on ill nourished "paid donors". The individual hospitals should be able to draw their requirements from the Central Blood Bank. They should also be able to return to the Bank such blood which has not been used and whose expiry date is imminent. The Bank should be able to run in addition, a plasma processing unit which is another crying need for this country. Although plasma is not the ideal fluid, The country can make a start and gradually extend to fractionation of plasma.

Each hospital should maintain a dispensing unit with a Blood Bank Officer who will collect blood only from relatives of patients in the hospital to supplement the supplies from the Central Blood Bank. For recommendations please refer to section on blood bank in para. 125. The Committee recommends:

(178) THAT THERE SHOULD BE A CENTRAL CONTROL ROOM FOR THE EMERGENCY AND ACCIDENT SERVICE.

- (179) THAT AMBULANCE SERVICE SHOULD BE CENTRALISED WITH ATLEAST 3 SUB-STATIONS IN DIFFERENT PARTS OF DELHI AND THAT WORKSHOP FACILITIES BE PROVIDED TO KEEP THE FLEET ON ROAD.
- (180) THAT THE AMBULANCES BE FITTED WITH WALKIE-TALKIE WIRELESS SERVICE.
- (181) THAT EMERGENCY DEPARTMENTS IN THE WILLINGDON, THE SAFDARJANG, THE LADY HARDINGE, THE IRWIN & THE HINDU RAO HOSPITALS SHOULD BE PROPERLY EQUIPPED & STAFFED TO HANDLE ALL ACCIDENTS AND EMERGENCY CASES.
- (182) THAT TRAUMA SURGERY UNIT SHOULD BE ORGANISED IN THE FIVE HOSPITALS.
- (183) THAT NEURO-SURGERY UNITS FOR TREATMENT OF HEAD INJURY CASES BE FULLY EQUIPPED IN THE A.I.I.M.S., THE WILLINGDON AND THE G.B. PANT HOSPITALS.
- (184) THAT EVERY MAJOR HOSPITAL SHOULD HAVE DISASTER PLAN.
- (185) THAT THE BLOOD BANK SERVICE SHOULD BE CENTRALISED WITH COLLECTING AND DISPENSING UNITS UNDER A BLOOD BANK OFFICER IN EACH HOSPITAL.

Medico-legal:

183. The medico-legal post-mortem work has not

been functioning entirely satisfactorily.

The Committee feels that the time lag of 18 to 24 hours after death for completion of post-mortem needs to be reduced. It recommends:

- (186) THAT FOR MEDICOLEGAL WORK DELHI MAY BE DIVIDED INTO THREE DISTRICTS AND EACH DISTRICT SHOULD HANDLE THE WORK ARISING IN ITS ZONE.
- (187) THAT ALL MEDICAL OFFICERS IN THE FORENSIC MEDICINE DEPARTMENT OF THE MAULANA AZAD MEDICAL COLLEGE AND ALL-INDIA INSTITUTE OF MEDICAL SCIENCES SHOULD BE AUTHORISED BY DELHI ADMINISTRATION TO PERFORM MEDICOLEGAL POST-MORTEMS.
- (188) THAT THE DELHI ADMINISTRATION SHOULD HAVE AT EACH OF THE THREE CENTRES TWO QUALIFIED MEDICAL JURISTS IN THE SPECIALIST GRADE; TWO POST-MORTEM TECHNICIANS & ANCILLARY SERVICE ROUND THE CLOCK AT EACH MORTUARY. ARRANGEMENTS FOR THE STAFF SHOULD BE MADE BY THE DELHI ADMINISTRATION WHICH IS RESPONSIBLE FOR LAW AND ORDER.
- (189) THAT AS THE POST-MORTEM IS CONDUCTED AT THE REQUEST OF THE POLICE, THE MEDICAL OFFICER CONDUCTING THE POST-MORTEM WILL NOT COMMUNICATE WITH ANY OUTSIDE AGENCY.

IF ANY ONE MAKES A REQUEST FOR A COPY OF POST-MORTEM REPORT, HE SHOULD BE DIRECTED BY THE MEDICAL OFFICER TO CONTACT THE POLICE AUTHORITIES.

Central Government Health Schemes

184. It is observed that 50% of the specialists in the Willingdon Hospital & Safdarjang Hospital are on the C.G.H.S. strength. They are attached to the hospitals and function as hospital staff at the out-patients and recommend admission. They also provide the domiciliary service and attend at the clinics. The patients recommended by them for admission are however not under their care in the wards/nursing home but under another set of medical officers.

The Committee feels that the hospitals should utilise the services of C.G.H.S. specialists also for indoor clinical work so that they can follow up the treatment and progress of patients whom they admit. This will greatly increase the confidence of the patient and improve the in-patient care whether in the hospital, or in the Nursing Home. The present dichotomy of treatment of C.G.H.S. patients by the C.G.H.S. specialists at the out-patients and by other hospital specialists as inpatients is not considered conducive to efficient patient care.

After discharge from the hospital, the CGHS patients have to go back to the CGHS specialists and thereby the continuity of treatment is broken.

The All India Institute of Medical Sciences should be actively associated with C.G.H.S. as a referral hospital affording such facilities as do not exist in the Willingdon and the Safdarjang Hospital. The services of experts and specialised investigational facilities should not be denied to C.G.H.S. beneficiaries.

185. The Committee has observed that the Director, Central Government Health Scheme, who should have the overall charge of treatment facilities of a C.G.H.S. beneficiary whether at the clinic, home, specialist consultation or in-patient treatment, has no liaison with the Safdarjang and the Willingdon Hospitals where C.G.H.S. patients are treated. Active association of Director, C.G.H.S., with the working of the hospitals can help in redressing and looking into the grievances voiced by beneficiaries. This situation has to be remedied if the Central Government Health Scheme is to serve as a precursor of National Health Service Scheme.

To enable the C.G.H.S. to function as a

pilot project for the national health insurance scheme, the Committee recommends:

- (190) THAT C.G.H.S. SPECIALISTS AT THE WILLINGDON AND THE SAFDARJANG HOSPITALS SHOULD BE CONSIDERED AS FULL FLEDGED HOSPITAL SPECIALISTS IN CHARGE OF UNITS WITH FACILITIES TO TREAT THEIR PATIENTS IN NURSING HOME/WARDS.
- (191) THAT ALL-INDIA INSTITUTE OF MEDICAL SCIENCES SHOULD BE RECOGNISED AS A REFERRAL HOSPITAL FOR THE BENEFICIARIES OF C.G.H.S. FOR THOSE FACILITIES WHICH DO NOT EXIST IN THE WILLINGDON AND THE SAFDARJANG HOSPITALS.

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#### 4.3. PLANNING AND DEVELOPMENT

186. In the earlier section of this Chapter, the need for co-ordination among different hospitals has been discussed. Absence of overall planning and co-ordination has led to haphazard growth of hospital services in Delhi area.

##### Regional Health Board:

187. An expanding city like Delhi, needs planned development of health services. This can be achieved only if and when the different controlling authorities of the Delhi hospitals are prepared to view the requirement for health care in the capital as a whole and accept the necessity for a central Regional Health Board consisting of representatives of the various planning, endowed with authority to plan, coordinate and advise future development.

188. To inspire confidence in the controlling authorities of individual hospitals and at the same time to be able to have its recommendations accepted and adopted by the participating agencies, the Regional Board should be high-powered. It should not be unwieldy. At the same time, due representation to the controlling authorities should be given.

Its functions will broadly be -

- (i) to plan development of health services in hospital, health centres, poly-clinics in the Union Territory of Delhi, on the recommendations of the Technical Committee;
- (ii) to formulate schemes on regional basis for special services e.g. emergency and accident care including ambulance service, blood bank, central purchase for medicines, equipments etc.
- (iii) to consider plans for allocation and development of specialities in different institutions;
- (iv) to arrange for appraisal/inspection of hospital services from time to time.
- (v) to recommend plan allocation of funds for development and deployment of man-power and resources.
- (vi) to invite, collect and accept donations for the hospital services from the public and to utilise the same for specific purposes, provided such acceptance or utilisation does not involve the govt. into any

additional expenditure for the hospitals and provided further that such donations do not violate the rules and orders that may be in force in this regard.

(vii) to make rules and regulations for the above objects.

189. The Committee suggests that a representative of each health administering authority in Delhi viz. Central Govt., Delhi Administration, Delhi Municipal Corporation, New Delhi Municipal Committee should be on the Board, presided over by the Union Health Secretary. The Director General of Health Services and the Director, G.O.H.S. should also be members. Two persons will be nominated by the Minister for Health. The Board will in addition have co-opted members representing other interests viz. Employees State Insurance Corporation, Railways, Defence, Delhi Medical Association.

Technical Committee:

190. An effective medical machinery for the Regional Board is essential to initiate schemes for planning of health services, specialities and expansion of hospital services and to advise on policy and planning programme of the metropolitan area. The Committee recommends that the Regional Board should have a Technical Committee manned by senior medical administrators and

experts in different specialities. The Technical Committee will advise the Board on all technical matters. All development schemes received by the Regional Board will be vetted and recommended by this Committee. It will also advise the Board on the appraisal of hospital services. The membership of the Committee will be Director General of Health Services - Chairman; Superintendents of all Hospitals, two technical experts of the speciality ( as required ) and Senior Architect of the Director General of Health Services as members.

The Technical Committee will have a number of sub-committees e.g. planning; appraisal of services in hospitals; specialities and allied services. Experts will be co-opted on the sub-committees depending on the speciality under consideration. Periodic review, atleast once in three years, will be organised by the Regional Board.

191. At the individual hospital level, as suggested in the earlier part of the report (para 103) there should be an executive Committee with Medical Superintendent as a Convenor, and Chairman of the Divisions of medicine, surgery, obstetrics and gynaecology, paediatrics, laboratories radiology etc.

as members. The functions of this Executive Committee will be to receive divisional reports, consider major medical policy and planning and co-ordinate hospital clinical activity without controlling or limiting the clinical freedom of individuals.

ZONAL COMMITTEE:

192. A further step to improve upon the health care facilities is to divide the territory of Delhi into 4 zones ( sectors ) with a population range of 7 to 10 lakhs, in each zone with at least one fully developed hospital with adequate provision for all types of specialized technical and treatment facilities including emergency and accident service. The hospital will participate in teaching and research activities and medico-legal work. At the sector level, the co-ordinating authority will be the Zonal Advisory Committee. Its functions will be

- a) to co-ordinate the functioning of different hospitals in the zone;
- b) to suggest ways and means to ensure liaison between various institutions;
- and

- c) to make recommendations to the Regional board on all matters pertaining to the Zone. The members the zonal committee shall be -
- Zonal Commissioner
  - Zonal Health Officer
  - three prominent citizens of the area and
  - Superintendent of the hospital in the area.

The proposed zonal sector distribution is shown in the sketch map of Delhi at Annexure .

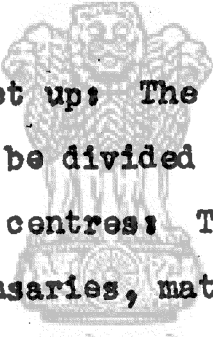
193. The Regional Board and its committees would require appropriate supporting staff and accommodation. The Committee recommends that the Secretariat of the Board should be located in the Union Ministry of Health. An Under Secretary/Deputy Secretary may act as a non-member Secretary to the Board.

The proposed set up of the Regional Board, Technical Committee etc. is given in the Organisational Chart at annexure.

Reorganisation and Zonal Distribution of Health Services.

194. The Committee after careful consideration

of the Report of Dr.K.N.Rao Committee (1963) appointed by the Ministry of Health for the Reorganization and Zonal Distribution of Health Services in Delhi, has come to the conclusion that the efficiency of medical care can improve only when the different services are co-ordinated. The Committee is in broad agreement with the recommendations made by the above Committee and suggests the implementation of the recommendations as under:-

- 
- (a) zonal set up: The city of Delhi should be divided into 4 sectors;
  - (b) health centres: The existing dispensaries, maternity and child welfare centres, tuberculosis clinics, school health services etc. should be converted into co-ordinate functional units (health centres), basic health workers and vaccinators connected with the immunization work should be attached to these health centres for immunization and preventive work. All future development should be visualized in terms of such health centres as peripheral service units. One

health centre should be provided for a population of 20,000. Delhi will thus require 200 health centres to cover the entire population.

- c) **Poly-clinics:** For specialized outdoor services including arrangements for laboratory and x-ray examinations near the residences of the patients, poly-clinics should be established in different parts of Delhi. Health centres will refer cases to these centres. To begin with, two such poly-clinics are recommended in each sector.
- d) **Inter-mediate hospitals:** For in-patient care of simple cases which unnecessarily crowd the teaching hospitals, the provision of 800 beds, 200 beds in each sector, at inter-mediate hospitals in the (four) sectors is recommended.
- d) **Sector Hospital:** Each sector will have a hospital equipped to deal with all types of patients. The poly-clinics and intermediate hospitals will refer complicated cases to the Sector Hospital. Emergency



and casualty service and medico-legal work will be based on the sector Hospital. It will also provide for 20-30 psychiatry beds, an isolation wing for treatment of communicable diseases except smallpox and cholera and a ward for chronic cases.

f) Infectious Diseases Hospital : An Infectious Diseases Hospital in south Delhi is considered necessary as the only existing I.D. hospital is in the extreme north.

g) Administrative set up: For service to patients, teaching and research and location of certain specialities, a very close collaboration among the different hospitals in each sector is necessary. It is suggested that the All-India Institute of Medical Sciences and the Safdarjang Hospital should form a single complex; the Willingdon and the Lady Hardinge should collaborate and the Irwin and G.B. Pant Hospital should function as one unit in the Maulana Azad Complex.

These 3 complexes are based on the medical colleges in the All-India Institute of Medical Sciences, the Lady Hardinge Medical College and Maulana Azad Medical College.

h) Emergency, accident and ambulance services:

These services continue to be inadequate. Control at 102 does not seem to function satisfactorily. It is recommended that there should be a Central Control Room for the emergency cases. The ambulance service should also be centralized at this control room.

i) Development of specialities: Besides treatment facilities for medical, surgical, obstetrics and gynaecology, eye, ear nose throat, orthopaedics, paediatrics and dental, all hospitals should have adequate diagnostic facilities of laboratory and x-rays. Certain specialities are recommended to be developed in the institutions as under:

Cardiology - i. Maulana Azad Complex  
ii. All India Institute of Medical Sciences.  
iii. Willingdon Hospital

Dermatology - All hospitals.

Psychiatry - Maulana Azad  
All-India Institute of Medical Sciences.

## Willingdon complex.

Neurology and Neuro-Surgery	1 1 1	Maulana Azad complex (Pant Hospital) All India Institute of Medical Sciences.
Gastro- enteriology -		Maulana Azad (Irwin Hosp)  All India Institute of Med. Sciences.
Cancer -		Safdarjang Hospital India All India Institute of Med. Sciences.  Maulana Azad complex (Irwin Hospital)  Lady Hardinge Medical College and Hospital.
Plastic Surgery.		Safdarjang Hospital  Maulana Azad complex
Chest Diseases	-	T.B. Hospital Kingsway T.B. Hospital, Mehrauli Vallabhbhai Patel Instt.
Radiation - Medicine.		Maulana Azad complex  All-India Instt. Safdarjang complex  Institute of Nuclear Medicine in University complex.
Dentistry -		Separate dental college to be established.

195. In the planning and development of health services it should be kept in mind that the health of the people has to be built on four

pillars viz.

efficient health services;  
 health professions;  
 cooperation of the voluntary organisations;  
 and  
 the public.

The Committee considers that all these four components are to be encouraged in building the future health services of Delhi. In this the general practitioner is, the most important component, whose services must be utilized in the hospitals and health services in future.

#### Future development

196. Taking into consideration the existing hospital facilities, the Committee recommends that there is an urgent need for development of the hospital services - general and special - in certain areas.

As for hospital care, three areas viz.

(1) Part of the Union Territory of Delhi on the East of Jumna River upto the border of U.P. (Trans Jumna area); (2) West Delhi and (3) North Delhi with rural suburbs are to be accorded first priority for addition of beds.

#### General Hospital:

197. Trans-Jumna area has a population of over

two lakhs. It is spread over a wide area. In the zonal distribution it is included in the East Sector with Irwin Hospital as referral hospital. River Jumna cut this area from the main Delhi city, communication is a real problem across the river. The Committee considers that a self-contained general hospital with adequate diagnostic and treatment facilities is required in this area. The Shadara General Hospital could be upgraded to have atleast 500 beds with supporting diagnostic and treatment facilities.

198. Civil Lines and Rural North - For this area the Hindu Rao Hospital is the only general hospital. As stated earlier, this hospital is deficient both in diagnostic and treatment service. It requires to be completely reorganized to bring it up to the level of a district general hospital with about 500-700 beds. It would then be possible to cater to the needs of this sector. The colony hospitals and health centres in the rural north should be upgraded to provide about 30 beds for routine in-patient treatment as country hospital with facilities to refer cases to the Hindu Rao Hospital.

199. West Delhi. The new colonies at Najafgarh Road West Patel Nagar, cannot be expected to

take full advantage of the Willingdon Hospital - firstly because of the distance and secondly because of the chronic bottleneck at the railway crossing near the Delhi Milk Scheme. There is also very heavy vehicular and goods traffic in this part of the town because of heavy industries. A general hospital of about 500 beds with provision for future expansion should be developed in this area. It is understood that a piece of land for the hospital has been earmarked near Tihar Village. This is practically on the farther end but in the absence of any other suitable plot, the construction of the hospital should be taken in hand immediately.

Infectious diseases hospital.

200. The only existing Infectious Diseases Hospital is in North Delhi. This has to be developed and modernised. The Committee recommends that another such hospital should be established in South Delhi.

Special disciplines

201. The Committee is of the considered view that Regional Health Board should be charged specifically with the responsibility to advise on the location of specialities in different hospitals. The concerned administrations

and the Planning Commission should undertake to consider any proposal on development of health services only after this has been examined by the Regional Board.

202. The Committee recommends that the Emergency and Accident Services, Central Blood Bank, Central Purchase Organization and workshop for maintenance of hospital instruments and equipment could better be developed on regional basis under the Regional Board.

#### Five Year Plan.

203. During the next 5 years all the existing hospitals have development plans. An outlay of about Rs.1200 lakhs is envisaged for the hospitals controlled by the Ministry of Health, two autonomous teaching institutions and Irwin and G.B. Pant Hospitals under Delhi Administration. ~~M.S.I.C.~~ which provides medical care to the industrial workers and their families has a plan to spend about Rs.240 lakhs in construction of a hospital complex of 924 beds and 14 State Insurance Dispensaries. Details of the financial outlay involved in the improvement of service facilities in the hospitals under the charge of Delhi Municipal Corporation of Delhi are not available.

204. The proposed schemes of each hospital during the next 5 years have been referred to earlier in chapter 3.2 ( Basic data of hospitals), Briefly these are

a) Willington Hospital has a proposal to construct an additional 750 beds (500 general plus 150 nursing home plus 100 casualty beds) raising the bed strength to about 1200 ; to develop specialities in cardiology, dermatology, psychiatry, pathology and bio-chemistry; to improve basic needs of CGHS patients and public patients in general medicine and surgery; to upgrade ancillary services including central sterilization services and laboratories and to provide an efficient casualty service round the clock.

b) The main schemes of construction for the Safdarjang Hospital are in respect of supporting services e.g. development of operation theatre facilities, OPD and emergency beds; nursing school and hostel and residential accommodation for staff. The additional beds are for emergency and infectious disease. Air conditioning of the hospital is also proposed.

c) All India Institute of Medical Sciences envisages development of departments in the teaching side of the institute and additional residential accommodation for staff and students.



- d) The proposed schemes for the Lady Hardinge Hospital are to make good the deficiency of accommodation and equipment in supporting services and residential accommodation for staff.
- e) The capital works in the Hindu Rao Hospital are in respect of such services which have very inadequate accommodation and are sub-standard for a busy hospital.
- f) The project schemes for the Irwin Hospital are for further inpatient and out-patient accommodation and additional specialized units.
- g) The employees State Insurance Corporation plans to construct a hospital and 14 State Insurance dispensaries.

205. The Committee is constrained to remark that lopsided development of hospital services in Delhi still continues. Not much headway has been made to bring up to satisfactory level the services available at Municipal Corporation hospitals. A number of departments in the Lady Hardinge Hospital also continue to be under-staffed badly accommodated and ill-equipped.

206. The Safdarjang, the Willingdon and the Irwin Hospitals have had unrestricted expansion,

both vertically and horizontally. The Safdarjang and the Irwin Hospitals have bed strengths of over 1000. The Willingdon has also its departments spread out. The administration of these 3 institutions is functioning under considerable strain. The Committee considers that no further scheme for additional beds in the Safdarjang, the Willingdon and the Irwin Hospitals be sanctioned. As referred to earlier, additional beds should be located in areas like West Delhi, North Delhi and trans-Jumna area where hospital facilities do not exist.

207. Of the existing hospitals, the first priority in allocation of funds should be given to hospitals run by Delhi Municipal Corporation to augment the meagre facilities in all spheres—accommodation, equipment and staffing. The Lady Hardinge Hospital should be considered on top priority basis. These proposed schemes are absolutely necessary for improving the service to patients.

208. The Committee further recommends that the plan programmes of different administrative authorities for health care in Delhi should be considered together bearing in mind, the development of zonal coverage. The proposed Regional Health Board so far as planned

development is concerned, could bring the different administrative agencies together to evolve a co-ordinated and balanced set up of hospital & health services in Delhi.

If a high quality of service is to be achieved economically, the only solution is co-ordination and planning. If the health sector is starved for resources, then the quality of Health must deteriorate. It is also true that the indiscriminate allocation of resources to a particular health service without a thorough examination of the consequences will result in lowering of quality of health care in the aggregate as the resources are deviated from other areas.

Proper allocation of health resources becomes vital if a uniform standard of efficiency is expected. The Committee feels that though expenditure on health services is an investment, the scarce resources should be utilized properly. However, commensurate with the expectation of a high standard of efficiency, there should be an equal enthusiasm in sanctioning funds for effecting improvements to achieve such a standard.

209. The Committee has carefully considered and has suggested in the fore-going paragraphs an effective means for co-ordination, planning

and evaluation to improve efficiency without in any way interfering with the internal administration of individual hospitals.

The Committee recommends:

- (192) THAT COORDINATION OF THE HEALTH PROGRAMMES OF THE VARIOUS ADMINISTRATIVE AUTHORITIES IN DELHI IS ABSOLUTELY NECESSARY TO ENSURE PLANNED DEVELOPMENT OF EFFICIENT HOSPITAL AND HEALTH SERVICES FOR DELHI.
- (193) THAT A HIGH POWER REGIONAL HEALTH BOARD SHOULD BE SET UP TO COORDINATE THE HEALTH SERVICES PROGRAMMES OF DIFFERENT ADMINISTRATIVE UNITS IN DELHI AREA.
- (194) THAT A TECHNICAL COMMITTEE BE APPOINTED TO ADVISE THE REGIONAL HOSPITAL BOARD ON ALL TECHNICAL MATTERS IN CONNECTION WITH THE PLANNED DEVELOPMENT OF THE HOSPITAL AND HEALTH SERVICES AND THE ECONOMIC UTILISATION OF HIGHLY SPECIALISED RESOURCES IN MATERIAL AND MANPOWER.
- (195) THAT THE SCHEME FOR REORGANISATION AND ZONAL DISTRIBUTION OF HEALTH SERVICES IN DELHI RECOMMENDED BY THE MINISTRY

OF HEALTH COMMITTEE IN 1963 SHOULD BE IMPLEMENTED.

- (196) THAT IN ANY FUTURE PLANNING AND DEVELOPMENT OF HEALTH SERVICES IN DELHI THE INTEGRATION OF THE GENERAL PRACTITIONERS IN THE ORGANISATION OF COMPREHENSIVE HEALTH SERVICES SHOULD BE KEPT IN MIND AND THEIR SERVICES UTILISED.
- (197) THAT ALL DEVELOPMENT PLANS FOR HEALTH CARE SHOULD IN THE FIRST INSTANCE BE CONSIDERED BY REGIONAL BOARD BEFORE THEIR BEING APPROVED BY THE CONTROLLING AUTHORITIES FOR INCLUSION IN THE DEVELOPMENT PROGRAMMES.
- (198) THAT TOP PRIORITY SHOULD BE ACCORDED TO SANCTION FUNDS TO IMPROVE LABORATORIES AND RADIOLOGICAL SERVICES, OPERATION THEATRES, CENTRAL SUPPLY SERVICES AND RESIDENTIAL ACCOMMODATION FOR ESSENTIAL STAFF.
- (199) THAT THE HINDU RAO HOSPITAL SHOULD BE PLANNED TO DEVELOP INTO A SECTOR HOSPITAL WITH A BED STRENGTH OF 500-750 WITH ALL THE SUPPORTING SERVICES.
- (200) THAT THE SHADARA GENERAL HOSPITAL BE DEVELOPED INTO ONE OF THE GENERAL HOSPITALS OF THE SECTOR UPTO 500 BEDS WITH ALL SUPPORTING SERVICES.

- (201) THAT A NEW GENERAL HOSPITAL OF 500 BEDS BE CONSTRUCTED IN WEST DELHI AS A PRIORITY.
- (202) THAT THE FUTURE DEVELOPMENT OF THE HOSPITAL AND HEALTH SERVICES SHOULD BE ON A ZONAL AND REGIONAL BASIS. THE HEALTH CENTRES, THE POLY-CLINICS THE GENERAL HOSPITAL AND THE SECTOR REFERRAL HOSPITAL SHOULD ALL BE LINKED WITH EACH OTHER. THE EXISTING HOSPITALS LIKE AIIMS/SAFEDARJANG, WILLINGDON/LADY HARDINGE MEDICAL COLLEGE, IRWIN/PANT HOSPITALS SHOULD BE MODERNIZED AND BROUGHT OUT TO AN EFFICIENT LEVEL BEFORE PERMITTING ANY FURTHER EXPANSION OF BEDS, AS MOST OF THESE HOSPITALS HAVE REACHED A SATURATION POINT. THERE ARE CERTAIN SECTORS IN THE DELHI AREA WHICH HAVE NO HOSPITAL OR HEALTH SERVICES. PRIORITY, THEREFORE, SHOULD BE GIVEN TO THE DEVELOPMENT OF HEALTH CENTRES, POLY-CLINICS, GENERAL HOSPITALS IN THESE AREAS.

#### 4.4. OTHER RECOMMENDATIONS

##### Economics of Health:

210. For a rational formulation of national and community health policies, it is very necessary to study the health expenditure pattern and its relevance to health planning. In a study made by the W.H.O. trends in expenditure on health services, and on different areas within such services was made to find out the causes of rising expenditure or on methods of financing it. In countries faced with acute shortage of money, educated manpower and technical skills, the report observed that it was particularly important that resources be used to the maximum social and economic advantage. Decisions had to be made on the share of resources to be devoted to health services and to particular areas within these services.

Hospital expenditure is the greatest single component of health cost and unless this is analysed and studied, it will not be possible for India to find out ways and means of effecting economy in and at the same time improving the health services within the available resources.

The countries found to be spending least on health services were naturally the poorest. They had the lowest taxable capacity and could hardly afford to provide anything more than the barest necessities of life. Thus poor health resulted from poverty

and poverty continued to be aggravated by poor health. This vicious circle had to be broken.

Health expenditure is influenced largely by the "felt needs" of the governments or those they govern. However, it is inevitable that the health spending of each country is also influenced by its history, by the standards of medical practice it has developed internally and by the extent and duration of its contact with other nations. The political, economic and social structure of the country and cultural factors such as evolution, the place of human life, the fear of death and the extent to which death and disease are considered proper fields for human intervention also govern a country's health expenditure pattern.

The cost on Drug Bill varies from State to State in a country and on an international level from country to country. This has been progressively rising in all countries.

For health planning it is necessary to have information on the resources available, the trends in health expenditure, the extent of existing health services, the reasons for difference in relative prices and the geographical distribution of health resources in the country. The studies of expenditure and costs are of little meaning unless they are related to benefits received, for which it is necessary to have information on utilisation of various health services, the reasons for variations



and the economic and social benefits of the individual and the nation. This raises major problem related to operational and epidemiological research.

The Committee recommends:

(203) THAT STUDIES ON TRENDS OF HEALTH EXPENDITURE, THE EXTENT OF HEALTH SERVICES, THE REASONS FOR DIFFERENCE IN RELATIVE PRICES AND THE GEOGRAPHIC DISTRIBUTION OF HEALTH RESOURCES SHOULD BE TAKEN UP IN VIEW OF THEIR GREAT IMPORTANCE FOR PLANNING FUTURE HEALTH EXPENDITURE FOR THE COUNTRY AS A WHOLE. SUCH STUDIES CAN BE UNDERTAKEN BY ORGANISATION LIKE THE NATIONAL INSTITUTE OF HEALTH ADMINISTRATION AND EDUCATION, THE INDIAN COUNCIL OF MEDICAL RESEARCH OR THE DIRECTORATE GENERAL OF HEALTH SERVICES.

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#### Health Insurance:

211. Sickness and disability entail both loss of earning power and extra expense. Health care today aims at promotion of positive health, prevention of disease, medical care in the event of sickness/disability at the home, clinic and hospital and rehabilitation to facilitate early return to productive work. Even in the limited sphere of treatment of disease or injury, it is beyond the capacity of an individual to meet the increasing cost of medical care. The State or the Society has, therefore, to provide the minimum necessary protection to the population.

In developing countries, with many problems like food, shelter, education and control of communicable diseases demanding immediate attention, it is well nigh beyond the resources of the State to find requisite funds for such a comprehensive medical care programme. The other alternative is for people to combine their efforts through public or private enterprise and evolve a scheme to meet the needs of the Society for promotion and preservation of health. This is the object of health insurance. The Central Government Health Scheme for government servants and the Employees' State Insurance for Industrial Workers are the two pioneer schemes in this direction. The Committee considers that in India community health care can be organised through health insurance and that it should be the sheetanchor in all future Health Development programmes. It would be unrealistic not to appreciate the need for building up resources for such programmes when the State is unable to provide the same.

In Delhi a substantial percentage of population is already in receipt of medical care under the C.G.H.S. and the E.S.I. Scheme. Delhi is well suited to have a scheme of community health care through health insurance by progressively bringing in more and more sections of the population into the existing schemes. In any scheme

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of Health Insurance active participation of general medical practitioners to the maximum extent would be desirable.

The Committee recommends:

(204) THAT THE HEALTH SERVICES COULD BE FURTHER EXPANDED BY THE INTRODUCTION OF A HEALTH INSURANCE SCHEME.

Accreditation of Specialists and Hospitals:

212. A progressive step towards improving the efficiency of the hospital services and providing continuous incentive towards such improvement is the system of accreditation of specialists and hospitals prevalent in certain advanced countries. Accreditation gives public recognition to the degree of competence of an institution, its various special services and the specialists in various disciplines by awarding them grades. Everyone, institution as well as individual, will, therefore, aim to reach the highest grade and retain that status. The efficiency of both will improve. Unplanned development of higher disciplines with inadequate resources will not be attempted. The public will be able to avail themselves of the best services in any speciality.

The Committee, therefore, recommends

(205) THAT A HOSPITAL ACCREDITATION COUNCIL BE ESTABLISHED ON THE LINES OF THE INDIAN MEDICAL COUNCIL TO ASSESS HOSPITAL SERVICES AND AWARD THEM APPROPRIATE GRADES.

(206) THAT THE SPECIALISTS BE GIVEN RECOGNITION

Resources:

213. Until Health Insurance is introduced on a mass scale, it is for consideration if graded hospital stoppages based on the income should not be recovered from the beneficiaries, in order to augment resources at least partially to meet the increasing expenditure on hospital beds. Paying wards should be provided in all hospitals, wherein the beneficiary should be required to pay for all the services provided by the hospital. The money so collected could be ploughed back into the hospital to improve its services. The Committee also recommends that hospitals may be permitted to invite, collect and accept donations from the public so long as these do not in any way increase the commitment of the Government and are within the prescribed rules.

Merit award

214. In the existing set up posting and promotion are regulated under the rules and regulations where other things being equal, seniority in service is an important criterion. The objective test of proficiency should be based on medical audit, publications and research. In the absence of posts in a higher scale, persons of out-standing talents are denied due recognition. There is a tendency for such persons to leave the organisation to better their prospects. For the outstanding officer in any field of health activity, recognition in the form of additional increment or special monetary awards may

Service in U.K. The Committee recommends:

(207) THAT GOVERNMENT SHOULD CONSIDER THE GRANT OF "MERIT AWARD" TO PERSONS OF OUTSTANDING MERIT IN THE MEDICAL SERVICES.

Expert Advice:

215. The Committee has broadly touched upon the deficiencies which require immediate attention.

Expert advice of WHO on certain areas should be taken up for technical assistance. The Government of India may obtain WHO consultant services for further study and advice on the implementation of recommendations in priority areas e.g. reorganisation of diagnostic services, development of Regional Hospital Board, hospital costing technique, health cash benefit analysis etc.

The Committee recommends:

(208) THAT THE SERVICES OF INTERNATIONAL AGENCIES LIKE WHO BE AVAILED OF FOR CONSULTANT SERVICES IN THE ORGANISATION OF THE REGIONAL HEALTH BOARD AND HEALTH SERVICE.

Hospital Review & Implementation Committee:

216. The Committee has noted that there was little follow up action taken by authorities on the recommendations of similar committees appointed in the past. It feels that there must be a standing Committee called the "Hospital Review & Implementation Committee" to follow up its recommendations and periodically review the progress achieved. It recommends:

(209) THAT THERE SHOULD BE A HOSPITAL REVIEW AND IMPLEMENTATION COMMITTEE TO FOLLOW UP ITS RECOMMENDATION

Doctor patient relationship:

217. The doctor patient relationship is one of the most sacred one where the patient comes with full faith and doctor gives his best services.

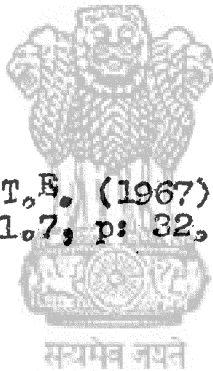
The Committee commends the following:

"It is doubtful if many doctors who actually care for the sick and the infirm plan their actions on the basis of the predicted effect upon society. Instead, the dominant tradition is for the physician to provide the best care of which he is capable for those who either seek his services or who are assigned to his responsibility; by and large this is done without regard for the conceivably broader issue of whether or not treatment is justifiable on social grounds. His reasons may include pride, altruism, compassion, curiosity, a spirit of competition, even avarice, or a combination of all these things. Whatever the motive, the reflexes which follow are sure, and respond similarly to the needs of the productive members of the community, the insane and feeble-minded, children with incurable birth defects, condemned criminals, or even soldiers who moments before were members of a hostile army.

"The foregoing viewpoint is a narrow one, but there is no reason to believe that it should

be abandoned in the face of advancing technocracy. It has shielded the ill from the caprices of the moral judgments of other men through centuries of evolving philosophical, religious and legal doctrines. It has placed the concept of the sanctity of human life on a practical foundation, since the responsibility of one person for another could not be more clearly defined than through the doctor-patient relationship, irrespective of the reasons for the contract entered into between the two involved parties".

Quotation from Starzl T.E. (1967)  
Ann. intern. Med. Suppl. 7, p: 32.



In the above report, we have endeavoured to give a faithful picture of the problems to be tackled in the coordinated development of the health services in Delhi in general and of the existing deficiencies in the hospitals in particular. While we are aware of the limitations imposed by many other problems facing the country in its efforts to improve the socio-economic status of the people, we would like to emphasise that positive health is as important as any other measure for the achievement of this goal. As has already been stated, poverty and poor health are links in the same vicious circle. Each tends to aggravate the other - one cannot be eliminated without eliminating the other. It is in this context we would like to request the Government in all earnestness to take early action to implement the above recommendations in a phased programme.

In conclusion the Chairman would like to place on record his deep appreciation of the whole-hearted cooperation, sincere advice and unanimity of views of the members of the Committee in all its deliberations and in the preparation of its report.

Sd/-  
K. N. Rao  
CHAIRMAN

Sd/-  
M. M. S. Siddhu

Sd/-  
K. K. Menon  
Maj. Genl.

Sd/-  
Shantilal J. Mehta

Sd/-  
B. K. Aikat

Sd/-  
A. Venogopal

Sd/-  
P. Diesh, Member-Secretary.

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(Para 56)

Copy of letter No. 31-19/63-M.II., dated 20th April, 1963 from the Director General of Health Services, New Delhi to the Medical Superintendent, Willingdon/Safdarjang Hospital/Lady Hardinge Medical College & Hospital, New Delhi.

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May I request you to kindly forward to this Directorate the rules & regulations or procedures laid down to effect a general lifting of the tone and efficiency of your hospital.

In this connection we would like to have your suggestions on the Departments mentioned below:-

1. Accounting.
2. Admitting Office
3. Blood Bank
4. Workshop for Braces.
5. Central Supply.
6. Services of Priest, Pandits etc.
7. Delivery Room.
8. Dietary.
9. Casualty and Emergency Services.
10. Engineering & Maintenance.
11. House-keeping.
12. Laboratory.
13. Laundry.
14. Library.

15. Medical Records.
16. Social Services - Volunteers.
17. Medical Staff.
18. Nursing.
19. Nursery.
20. Occupational Therapy & Physiotherapy.
21. Operation Theatre.
22. Recovery room.
23. Amenities to patients.
24. Personnel Administration.
25. Photography.
26. Others -
  - i. Internal decoration.
  - ii. External decoration as gardening etc.

It is requested that your reply on the above lines may please be furnished as early as possible and in any case not later than the 15th May, 1963.

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SUMMARY OF DISCUSSIONS WITH THE MEDICAL  
SUPERINTENDENTS OF HOSPITALS IN DELHI  
AND NEW DELHI AT 3.30 P.M. ON 6.3.1963.  
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PRESENT:

1. Dr. K.N. Rao,  
Additional Director General  
of Health Services;
2. Dr. M.J.H. Writer,  
D.A.D.G. of Health Services
3. Col. M.S. Rao,  
Medical Superintendent,  
Safdarjang Hospital.
4. Dr. B.L. Taneja,  
Medical Superintendent,  
Irwin Hospital.
5. Dr. H.L. Khosla,  
Medical Superintendent,  
Willington Hospital.

.....

1. Delegation of financial powers to Medical  
Superintendents of Safdarjang & Willington  
Hospitals.

It was stated that the financial powers of  
the Superintendents at present are very meage and  
inefficient to meet even the normal requirements of  
a good hospital.

Dr. Taneja stated that he had powers to the  
extent of Rs. 2500/- as head of the Department. Superin-  
tendent of the Willington & Safdarjang Hospitals to  
the extent of Rs. 10/- and Rs. 15/- respectively -  
non-recurring.

In the States the financial powers are to  
the extent of Rs. 1500/- for each item. If the efficiency  
of the hospitals in the city has to be improved upon it

is very necessary that the financial powers of the Superintendents of Hospitals are increased to Rs. 2500/- minimum as in the case of Irwin Hospital. It was noted that the prices of the articles costing about Rs. 500/- 3-4 years back now cost Rs. 2,000/- It is therefore recommended that the financial powers of the Medical Superintendents be increased to Rs. 2,000/- at least - recurring and they may be declared Heads of the Departments under S.R. 2(10) as well as under *DFR* Rules 1958.

2. Purchase powers:

The Superintendents reported that any article costing above Rs. 2,000/- has to be purchased only through Director General of Supplies & Disposals. Though indents were placed 2 years back articles have yet to come and this is causing inconveniences with regard to the proper functioning of the hospitals, as in some cases of drugs linen and such like essential equipment. Unless the purchasing powers of the Superintendents are enhanced to Rs. 10,000/- these procedural delays will prevent the proper functioning of the institutions.

It is understood that Director General of Supplies & Disposals is prepared to delegate powers up to Rs. 10,000/- so that the essential articles may be purchased by the Superintendents within time without having gone to Director General of Supplies & Disposals. It may also be noted that the prices of articles costing Rs. 2,000/- some years

back are now costing Rs. 6,000/- to Rs. 7,000/- and more. Therefore it is very necessary to accept the above suggestions.

It is also recommended that the purchasing powers of the Medical Superintendents in the city may be enhanced to Rs. 10,000/-

3. Recommendations of the work Study Team:

i. Assistance to Specialists:

As the Specialists & Doctors are doing routine unskilled work with regard to filling up of forms etc., L.D.C. knowing Shorthand preferably for clerical assistance will be of great value to improve the efficiency as also give much time for the Specialists to attend to emergencies etc.

ii. Clerical assistance to make appointments for each Specialists: It is considered that if the L.D.C. under (i) is sanctioned he will be able to perform these functions adequately.

iii. As it is not possible to readjust within the existing staff it is necessary to recommend the creation of posts of L.D.Cs for Specialists.

iv. Paediatric Care in city hospitals and attention to emergencies - Safdarjang Hospital:

150 - Medical Beds;

50 - Surgical Beds

200 - Beds

25 - Orthopaedics.

2½ Paediatric Units each consisting of 1 Paediatrician, one Junior Paediatrician, one Assistant Surgeon; one House-Surgeon and one Registrar are required. If sanctioned there will be no further complaint. New-natal and Out-patients Department should be separate consisting of Junior Paediatrician, Assistant Surgeon, Registrar and 2 House-Surgeons.

Willingdon Hospital:

Outpatients - 250

Air-conditioned:

Requirements:

Paediatrician - 1

Registrar - 1

Asstt. Paediatrician - 1

House Surgeon - 1

For the Summer more air-conditioning sets will be required.

Lady Hardinge:

Beds - 58

Kalavati Saran Children Hospital - 400-500 - Outpatients  
Staff & accommodation is very inadequate and some equipment is also very necessary.

In view of the inadequate accommodation, staff and equipment it is considered necessary to survey the present situation in Delhi Hospitals and make

of Paediatric care.

Additional Director General desired Dr. Writer to trace the Ministry of Finance letter to the Ministry of Health regarding staff pattern etc.

Additional Director General

also desired Dr. Writer to send a proforma to be sent to the Hospitals in Delhi and New Delhi to obtain the information on accommodation, equipment and staff and they should reply within a week.

After the returns are received it would be possible for local Inspection and discussions to resolve the problems with the Superintendents to make the recommendations.

Irwin Hospital:

Bed strength has been increased by another 30-75 medical beds - 1 Senior Paediatrician, 1 Junior Paediatrician, 1 CAS Grade I, 2 Registrars, and 3 House Surgeons - Paediatrician looks after the children Orthopaedic children and new-natal cases as they require 24 hour care.

Additional Director General again stressed that the Ministry of Health should be contacted and the letter of the Ministry of Finance regarding staffing pattern of hospitals should be traced and action taken so that most of the present difficulties of the hospitals could be met.

Reorganisation of hospital services:

It was noted by the participants that the hospitals

in Delhi area are run by different administrations without any co-ordination. The hospitals running under the Ministry of Health have very little co-ordinated services. It was generally agreed that a Regional Hospital Board be constituted to have a co-ordinated approach to the development of hospital services in the Delhi area so that duplication of services can be avoided and the hospital services in Delhi and New Delhi could be improved upon.


#### Constitution of the Committee

Chairman:

- i. Representative of the Ministry of Health;
- ii. Representative of the Ministry of Finance;
- iii. Representative of the Directorate General of Health Services;
- iv. Representative of the various administrations/ Corporation/Delhi Administration;
- v. Representative of the All India Institute of Medical Sciences, New Delhi.
- vi. Representative of the Contributory Health Service Scheme.
- vii. Medical Superintendents of Safdarjang Hospital, Willingdon Hospital, Irwin Hospital, Lady Harding Medical College & Hospital, Mehrauli T.B. Sanatorium, Hindu Rao Hospital, Silver Jubli Hospital and all others from public hospitals as well as Co-opted members like Dr. Sen.



STANDING ORDERS

1. Historical - Origin, growth and traditions.
2. Organisation.
3. Hospital timings.
4. Code of conduct for staff (turn out, attitude to service and courtes<sup>y</sup>).<sub>^</sub>
5. Duties of various members of staff.
6. Education, training of medical, nursing & other para-medical personnel.
7. Weekly inspections by Medical Superintendent.
8. Accounts.  
सत्यमेव जयते
  - (a) Cash
  - (b) Stores (i.e. medical, general, linen, rations, etc.)
  - (c) periodic checks
  - (d) Condemnation board
  - (e) Annual stock verification
  - (f) Internal audit
9. Security orders.
  - (a) Cash (Accounts)
  - (b) Cash and valuables of patients.
  - (c) Hospital property
10. Fire orders.
11. Procedures
  - (a) Out-patient Department

Sanitation:

For general sanitation of the hospitals it was considered necessary that a Sanitary Squad, supervised by a Sanitary Inspector for each hospital be sanctioned to improve the sanitary conditions in the hospitals. Proposals from the Superintendents may be called for.

Standing Orders:

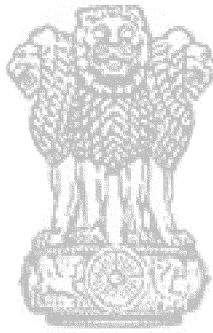
A copy of the Standing orders may be asked for from each hospital.

Public Relations and Toning up of the Administration:

It was generally agreed that there is a need to tone up the administration to improve public relations of the hospitals. Superintendents of the hospitals were requested to hold staff conferences, after short intervals, with all the medical members of staff and should impress upon them the need for improving the efficiency as well as public relations.

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13. Sanitation
14. Disaster Plan
15. Standing Committees, their constitution and charter of duties.



सत्यमेव जयते

- (b) Admission/discharge/transfer
- (c) Investigations
- (d) Medico-legal cases
- (e) Handling & disposal of dead bodies
- (f) Indenting for diets, medical stores, linen etc.

12. Hospital services.

- (a) O.P.D.
- (b) Casualty
- (c) Wards
- (d) Laboratory
- (e) X-ray
- (f) Physiotherapy
- (g) Prosthesis
- (h) Follow up
- (i) Medical records
- (j) Dispensary/Pharmacy
- (k) Ambulance
- (l) Inter-communication
- (m) Library
- (n) Research
- (o) Intensive Therapy
- (p) Blood Bank
- (q) Public Relations
- (r) Health education and preventive inoculation

HOSPITAL EXECUTIVE COMMITTEE (INDIVIDUAL HOSPITAL)

Chairman: Medical Superintendent Hospital

Chairman Division of Medicine	Division of Surgery	Division of Paediatrics.	Div. of Laboratory	Div. of X-ray	Co-opted members Lay administrative Matron.
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REGIONAL HEALTH BOARD

MEMBERS: Director General of Health Services

New Delhi Municipal Committee

Secretary (non-member)  
An officer of Ministry of Health

CHAIRMAN - SECRETARY, Ministry of Health  
Director, Delhi Administration  
CGHS

2 persons nominated by Minister for Health

Municipal Corporation

Co-opted members:  
E.S.I.C.  
Railways  
Defence  
D.M. Association

Technical Committee

Chairman - D.G.H.S.

Members - Superintendents of three Hospital complexes, Dir. CGHS, Supdt. Medical Services, Architect, M.O.H. Delhi M.C. & NMC Vol. Hospitals (Indian Hospital Assn.) Experts to be co-opted.

Planning

Appraisal of Hospitals and Services

Specialties & Regional services.

Zonal Advisory Committees

(4)

Zonal Commissioner  
Zonal Health Officer  
Three citizens

Superintendents of Hospitals

Rep. of CGHS.